EXHIBIT 8

In the Matter Of:

K.C., ET AL

-v-

INDIVIDUAL MEMBERS OF MEDICAL LICENSING BOARD OF INDIANA, ET AL

Dr. Catherine Bast + Michelle (Mixhi) Marquis, 30(b)(6) Mosaic

May 15, 2023

30(b)(6)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., et al.,)
)
Plaintiffs,)
)
-v-) CASE NO.
) 1:23-cv-00595-JPH-KMB
THE INDIVIDUAL MEMBERS OF)
THE MEDICAL LICENSING BOARD)
OF INDIANA, in their official)
capacities, et al.,)
)
Defendants.)

The 30(b)(6) deposition upon oral examination of MOSAIC HEALTH AND HEALING ARTS, INC., by DR. CATHERINE BAST and MICHELLE (MIXHI) MARQUIS, witnesses produced and remotely sworn before me, Debbi S. Austin, RMR, CRR, Notary Public in and for the County of Hendricks, State of Indiana, taken on behalf of the Defendants via Zoom videoconference on May 15, 2023, at 9:37 a.m., pursuant to the Federal Rules of Civil Procedure.

STEWART RICHARDSON & ASSOCIATES
Registered Professional Reporters
(800)869-0873

APPEARANCES
(All participants via Zoom videoconference)

FOR THE PLAINTIFFS:
Kenneth J. Falk, Esq.
Stevie Pactor, Esq.
Gavin M. Rose, Esq.
ACLU OF INDIANA
1031 East Washington Street
Indianapolis, IN 46202
kfalk@aclu-in.org
spactor@aclu-in.org
grose@aclu-in.org
Chase Strangio, Esq.
AMERICAN CIVIL LIBERTIES
UNION FOUNDATION
125 Broad Street
New York, NY 10041
cstrangio@aclu.org

FOR THE DEFENDANTS:
Thomas M. Fisher, Esq.
Razi Lane, Esq.
OFFICE OF THE ATTORNEY GENERAL
302 West Washington Street
IGCS Fifth Floor
Indianapolis, IN 46204
tom.fisher@atg.in.gov
razi.lane@atg.in.gov

ALSO PRESENT: Shawn Weyerbacher
Brad Davis

INDEX OF EXAMINATION

INDEX OF EXHIBITS

INDEX OF EXHIBITS (CONT'D.)

Page 5

THE REPORTER: My name is Debbi Austin, an associate of Stewart Richardson & Associates, One Indiana Square, Suite 2425, Indianapolis, Indiana. Today's date is May 15, 2023. The time is 9:37 a.m. This deposition is being held via Zoom videoconference. The deponent is Mosaic Health and Healing Arts, Inc.

Will counsel please identify themselves and any persons present with you for the record.

MR. FALK: This is Ken Falk for the plaintiffs here in person with the deponents. On the line are Gavin Rose and Stevie Pactor from the ACLU of Indiana and Chase Strangio from the ACLU in New York for the plaintiffs.

MR. FISHER: This is Tom Fisher with the Attorney General's Office taking the deposition. With me here on video is Razi Lane, also of our office. I think -- yeah, he's the only other one from the State.

Page 6

DR. CATHERINE BAST and MICHELLE (MIXHI) MARQUIS, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, were examined and testified as follows:

EXAMINATION

BY MR. FISHER:

Q Okay. Good morning Dr. Bast, Ms. Marquis. I don't know if I should address you so formally or if there are other names you would like me to use for you?

MIXHI MARQUIS: Mixhi is fine.

Q Mixhi. Doctor, you want me to call you Doctor?

DR. CATHERINE BAST: Yes, please.

Q Will do. Very good.

Well, so probably you've spoken about this with Mr. Falk, but I'm just going to go through a couple of kind of ground rule-type things, so just bear with me for a second here. So I'm going to ask you some questions. The court reporter is going to record everything we say. Obviously you need to answer the questions with the truth.

I'm going to assume that you understand my questions unless you tell me that you don't. But if you don't, please speak up. I've been known to ask many terrible questions. And that people don't understand and we can work through that.

You need to give verbal answers, not gestures. I think given especially that we're doing this remotely, that's going to be especially important. I just can't read body language as well remotely.

Doctor, is there any reason you cannot understand my questions today?

DR. CATHERINE BAST: No.

Q Mixhi, is there any reason you cannot understand my questions today?

MIXHI MARQUIS: No.

Q Well, I see that Mr. Falk is there with you. Is there any other person in that room with you?

DR. CATHERINE BAST: No.

MIXHI MARQUIS: No.

DR. CATHERINE BAST: The door is closed.

Q Okay. Well, other than meeting with your attorneys, did you do anything else to prepare for today's deposition, Doctor?

DR. CATHERINE BAST: I reviewed our complaint and my statement.

Q By the statement, you mean the declaration you signed?

DR. CATHERINE BAST: Yes.

Q Great. Anything else?

Page 8

DR. CATHERINE BAST: No.

Q No? Okay.

Mixhi, other than meet with your attorneys, what did you do to prepare for today's deposition?

MIXHI MARQUIS: The same. I read the complaint, read the declaration, made sure I was familiar with all of that.

Q Doctor, are you being compensated for today's testimony?

DR. CATHERINE BAST: No.

Q Mixhi, are you being compensated for today's testimony?

MIXHI MARQUIS: No.

Q Doctor, do you have any documents opened in the room with you or on the screen that we can't see?

DR. CATHERINE BAST: No. We have just the -- What are those called?

MR. FALK: The exhibits.

DR. CATHERINE BAST: We have the exhibits. There you go. We have the exhibits, that's all.

Q Okay, great. So let's start with the first of those exhibits, and this will be Exhibit 1, the amended Mosaic 30(b)(6) deposition notice.

MR. FISHER: Shawn, do you have that?

SHAWN WEYERBACHER: Yes, just one moment.

Page 9

(Deposition Exhibit 1 marked.)
Q Doctor, does this document look familiar to you?
DR. CATHERINE BAST: Yes.
Q Mixhi, does this document look familiar to you?
MIXHI MARQUIS: Yes.
Q So this is -- I'll just represent for the record, this is the Notice of Deposition that we have served.
Doctor, is it your understanding that you're here in response to this notice today?
DR. CATHERINE BAST: Yes.
Q Mixhi, is it your understanding that you are here in response to this notice today?
MIXHI MARQUIS: Yes.
(Deposition Exhibit 2 marked.)
Q Great. All right. Let's go to Exhibit 2, which is the attachment to the deposition notice.
Doctor, have you seen this document before?
DR. CATHERINE BAST: Yes.
MR. FALK: Tom, if I can interrupt. I actually have hard copies of most of this, so you'll see me passing papers back and forth. That's what it is.
MR. FISHER: Perfect.
MR. FALK: So she can go to page 2 without too

Page 10

much trouble, page 3.
MR. FISHER: Great, great.
Q Okay. So Doctor -- and I'm sorry, you said you have seen this before, Doctor?
DR. CATHERINE BAST: Yes.
Q And Mixhi, you've seen this before, this attachment?
MIXHI MARQUIS: Yes.
(Deposition Exhibit 3 marked.)
Q Okay. I'm sure we'll come back to that in a minute, but let's move on to Exhibit 3, which is a -- it's called designation of deponents.
Okay. Doctor, you've seen this document?
DR. CATHERINE BAST: Yes.
Q And it says, Doctor, that you are here to testify with respect to paragraphs 1 through 9 of the previous exhibit, which is the attachment?
DR. CATHERINE BAST: Yes.
Q Is that your understanding?
DR. CATHERINE BAST: Yes.
Q Mixhi, you've also seen the designation?
MIXHI MARQUIS: Yes.
Q And it says that you are here to testify with respect to paragraphs 10 through 14 and 15A of the attachment?

Page 11

DR. CATHERINE BAST: Correct.
Q And you're prepared to do that today?
MIXHI MARQUIS: Yes.
(Deposition Exhibit 4 marked.)
Q All right. Let's mark the next document, Exhibit 4, Defendants' First Requests for Production to the Plaintiffs.
Doctor, have you seen this document before?
DR. CATHERINE BAST: Yes.
Q Can you tell me what this document is?
DR. CATHERINE BAST: This is a request for documents that we -- asking for documents from Mosaic.
Q Were you involved in preparing the response to this document?
DR. CATHERINE BAST: Yes.
Q Mixhi, are you familiar with this document?
MIXHI MARQUIS: Yes, I am.
Q Were you involved in preparing the response to it?
MIXHI MARQUIS: Yes.
(Deposition Exhibit 5 marked.)
Q All right. Let's go to -- I guess what are we up to now, 5; right? Yes, response -- the response to the document request.
Great. All right, Doctor, are you familiar

Page 12

with this exhibit?
DR. CATHERINE BAST: I am, yes.
Q And you were -- again, you were involved in preparing this response?
DR. CATHERINE BAST: Yes.
Q Mixhi, do you recognize this document?
MIXHI MARQUIS: Yes.
Q And you were involved in preparing the response?
MIXHI MARQUIS: Yes.
Q Now, your counsel did produce to us several documents responsive to this request. However, there are also many objections, and there are some documents I think have been withheld on various grounds. I don't need to get into any of that.
My only question at the moment is, do you have any additional documents since the production that you have come across that are responsive that you need to produce to us?
DR. CATHERINE BAST: No.
MIXHI MARQUIS: No.
(Deposition Exhibit 6 marked.)
Q Okay, great. All right. Let's go to the next exhibit, the declaration of Mixhi Marquis.
Mixhi, I assume you recognize this document?
MIXHI MARQUIS: Yes.

Page 13

Q All right. Let's turn to page 7.
And is that your signature, Mixhi?
MIXHI MARQUIS: Yes, it is.
Q Okay. Can you just tell us what this declaration is?
MIXHI MARQUIS: This declaration is my statement of who I am and who Mosaic is.
Q And is this the same declaration that you submitted in this case into the case with the complaint?
MIXHI MARQUIS: Yes.
Q Is there any respect in which this declaration is no longer accurate?
MIXHI MARQUIS: No.
Q Mixhi, I'm still with you. Can you just describe for us your educational background?
MIXHI MARQUIS: My educational background is I have a bachelor's of science in mechanical engineering. And yeah, that is my -- that is my further education.
Q Where did you get your degree?
MIXHI MARQUIS: General Motors Institute in Flint, Michigan.
Q Oh, very good. My father is from Flint. That's interesting. I really enjoyed Flint when I was a kid.

Page 14

Okay. So have you -- do you have any peer reviewed scholarship, Mixhi?
MIXHI MARQUIS: No, I do not. I do have a -- I did graduate from massage -- a massage program in, I believe, 2014. But I am no longer licensed. I've let my license lapse.
Q Got you, okay. So other than -- well, leading up to, I guess, your involvement with Mosaic -- and we'll get to that in a moment -- I'm just wondering about your more general professional background, if you could describe that for us.
MIXHI MARQUIS: I worked in the automotive field for nine years. I've owned my own business. And yeah, and then helped create Mosaic.
Q What business did you own?
MIXHI MARQUIS: Marquis Events, Incorporated.
Q What -- I can imagine, but please tell us what kind of a business that was.
MIXHI MARQUIS: I did some event planning. I did some -- yeah, mostly event planning was that business. I did massage -- my massage business was under that as well.
Q I see. I was going to ask about that. So that was part of that, was you did --
MIXHI MARQUIS: Yeah, it was -- the doing

Page 15

business as name was Artistry of Presence, which is what I did massage therapy under.
Q Okay. What is your role at Mosaic?
MIXHI MARQUIS: I am the executive director.
Q And what do you do in that capacity?
MIXHI MARQUIS: I do things like work with the budget. I work with our board of directors. I am also -- do a lot of training. I do our -- the training that we offer in the community and to other organizations. So I oversee and help create that. And then general kind of supervising of staff and visioning forward.
Q Sorry, visioning forward, you said?
MIXHI MARQUIS: Yeah.
Q What does that mean?
MIXHI MARQUIS: Visioning for Mosaic, like how we move forward as an organization.
Q Okay. When you talked about the training in the community, what kind of training are you talking about?
MIXHI MARQUIS: We offer -- when organizations reach out, we offer just general LGBTQ competency. I do not do any clinic training. I do general competency training for community organizations. Churches, medical and mental health organizations

Page 16

for their -- for only their -- for their admin staff and completely nonclinical training when I do it.
Q Do they pay you for that?
MIXHI MARQUIS: Yes.
Q Do you have like an hourly rate you charge or something?
MIXHI MARQUIS: We have a general fee. We often reduce it. We often do things for free because the organizations we're working with often can't afford it.
Q What is your usual and customary fee?
MIXHI MARQUIS: Somewhere around 250 an hour, which is really unusual for us to get that.
Q What -- and how many hours typically does it -- do you devote to training a particular entity?
MIXHI MARQUIS: One to three.
Q And how long have you been employed at Mosaic?
MIXHI MARQUIS: Since the start. I co-founded Mosaic with Dr. Bast. So seven years.
Q Seven years, okay. And that -- have you held any other jobs or titles at Mosaic since starting it up besides executive director?
MIXHI MARQUIS: No.
Q Are you affiliated with any political associations?

Page 17

MIXHI MARQUIS: No, I don't believe so. Yeah, no.

Q Okay. Have you been involved in any political activism regarding the availability of transgender care, especially -- particularly with respect to youth?

MIXHI MARQUIS: No, I haven't, not until -- not until now.

Q Until now meaning?

MIXHI MARQUIS: Meaning the lawsuit.

Q The lawsuit, okay. Have you ever done any lobbying on issues related to transgender care for minors?

MIXHI MARQUIS: No.

Q Did anyone on the staff of Mosaic testify at the legislative hearings for SEA 480?

MIXHI MARQUIS: No.

(Deposition Exhibit 7 marked.)

Q All right. Now we're going to turn to Dr. Bast. I'm going to go through some background. Let's ID Exhibit 7, the declaration of Dr. Catherine Bast. Dr. Bast, do you recognize this document?

DR. CATHERINE BAST: I do.

Q And let's turn to page 7. Is that your signature?

DR. CATHERINE BAST: Yes.

Q And so just tell us what this document is, please.

Page 18

DR. CATHERINE BAST: This is my statement of my role at Mosaic and also my reasons for -- to -- participating in the lawsuit.

Q This was the declaration submitted in the lawsuit with the complaint?

DR. CATHERINE BAST: Correct.

Q Okay. Is there any --

MR. FALK: Just, Tom, for the record, I don't think it was submitted with the complaint. I think it was submitted with the preliminary injunction materials.

MR. FISHER: Oh, with the preliminary injunction, very good. Thank you, Ken.

Q Is there any respect in which this declaration is no longer accurate?

DR. CATHERINE BAST: No.

Q Can you, Doctor, please describe your educational background.

DR. CATHERINE BAST: So I was a certified professional midwife from 2003 through 2006, and then I went to IU School of Medicine in 2009 and graduated in 2013. And then I went to residency at the Memorial family medicine residency in South Bend and graduated from there in 2016.

Q What about undergraduate education?

Page 19

DR. CATHERINE BAST: I went to Mount Holyoke College, and I graduated from there in 1992.

Q And so it sounds like there was a period of time between your undergraduate education and when you became a certified midwife?

DR. CATHERINE BAST: That's correct.

Q What did you do during that period?

DR. CATHERINE BAST: I was a pastor's wife. I was a mom of three children, and I stayed at home with them.

Q And I'm sorry, you may have said this, but I want to make sure I caught it. What was your major at Mount Holyoke?

DR. CATHERINE BAST: I was an art history major at Mount Holyoke.

Q Do you have any peer reviewed scholarship?

DR. CATHERINE BAST: I do not.

Q So just describe for us your role at Mosaic.

DR. CATHERINE BAST: So I am the co-founder with Mixhi and also the medical director and the only physician at Mosaic. So I oversee the medical care here. I also regularly am seeing patients on a full schedule. I'm also -- yeah, I'm also involved in training. So when a clinical entity reaches out and asks us for training, I often will

Page 20

go and provide LGBTQ competency training for them.

I also am an assistant professor at the IU School of Medicine in clinical supervision because we offer CMEs here for other medical and mental health providers for LGBTQ competency training as well as trans care.

Q The competency -- I'm sorry, I didn't mean to interrupt. Were you finished?

DR. CATHERINE BAST: Well, I was also going to say that I've been invited by the American Academy of Family Physicians to present at the annual conference in October in Chicago about LGBTQ competency and care for trans people.

Q When you speak about the competency, the LGBTQ competency, is that the same thing that Mixhi was talking about, is that the same kind of training?

DR. CATHERINE BAST: Very similar, yes, yes.

Q Well, you say very similar, but is there anything materially different?

DR. CATHERINE BAST: Well, when I do trainings in clinical spaces, I try to apply the principles that we're using in the LGBTQ competency to clinical spaces. So I'm -- yeah, I'm lodged in that context.

Q Okay. It's just a different context, that's the

Page 21

difference?
DR. CATHERINE BAST: (Affirmative nod.)
Q But then you also spoke about trans care, and I take it that that's more on sort of the medical side?
DR. CATHERINE BAST: Yes.
Q And do you do trainings with trans care as well?
DR. CATHERINE BAST: I do.
Q Okay. Just tell us about that a little bit, please.
DR. CATHERINE BAST: So we offer training. It's a two-day training. It's called the Mosaic Experience. And the first day is didactics, and we invite providers to come to our space. So it's usually a small group. We spend the first day doing general basic LGBTQ competency, how to be -- create a welcoming space for LGBTQ people, and then I spend time talking about protocols for hormone therapy and, yeah, following up with trans folks.
Q Okay. Anything else that is involved with that? As people -- you know, as some of your clients move along, do they come back to you for additional information and training?
DR. CATHERINE BAST: So we also do have a group through -- yes, we have an alumnus group, we

Page 22

call it, which is a group of folks who have come through our training, and we meet as needed for support and further clarification. So I serve then as a mentor to the folks who have come through the training.
Q Describe your involvement as a member of WPATH.
DR. CATHERINE BAST: I went to WPATH training in 2014 in Atlanta and have been a member of WPATH. I regularly get their newsletters, and their protocols are central to the protocols for our care at Mosaic.
Q Do you serve on any committees?
DR. CATHERINE BAST: No.
Q What about the Gay and Lesbian Medical Association, GLMA; what is that?
DR. CATHERINE BAST: It's an association of -- a volunteer association for medical providers who identify in the LGBTQ plus community, and I'm a member, partly, to keep up on news and information. I also -- if I -- as a member, I'm also on -- available as a search for patients or other providers looking for LGBTQ identified and friendly medical providers.
Q Is there anything else to the membership? I guess I'm wondering here again about committees. Any

Page 23

committees that you serve on?
DR. CATHERINE BAST: No.
Q Any leadership positions?
DR. CATHERINE BAST: No.
Q Okay. Do you engage in any political activity?
DR. CATHERINE BAST: No.
Q Are you a member of any political organizations?
DR. CATHERINE BAST: No.
Q Are you a member of any other transgender-related organizations?
DR. CATHERINE BAST: No.
Q Are you involved with any transgender-related advocacy groups?
DR. CATHERINE BAST: No.
Q Tell us a little bit about how and when Mosaic got started. I understand it was you and Mixhi that started it together. I'm just a little -- I'm interested in learning a little bit more about the founding, sort of the when and the why.
DR. CATHERINE BAST: Uh-huh. So Mosaic was founded in 2016 at the end of my residency time, in response to a crisis. There were a number of trans people looking for care, mostly primary care, in a friendly environment, but also -- also some hormonal support in Indiana that had no place to

Page 24

go. And I, through word of mouth, by the end of my residency had 80 trans patients from all across the northern Indiana corridor.
And I -- as I interviewed for positions locally, I couldn't find a place that was willing to create a welcoming space for these patients. And these were patients that I had started to care for. There was nobody in the residency program coming behind me who was going to take their care over. So these were 80 patients who needed a medical home.
And Mixhi and I decided that the only answer to that, since I couldn't find a place to do it that was already established, was to establish our own. We have been blessed with a number of synchronicities and partners in this work and a number of different -- yeah, and we're glad to be here.
Q Tell me again about your residency. What was the focus of it?
DR. CATHERINE BAST: I'm a family medicine doctor. It was a family medicine residency.
Q And what does that -- what did that mean in the context of your residency, specifically? What were you doing?

Page 25

DR. CATHERINE BAST: I was doing care for humans from pregnancy through death.

Q And typically what were your patients coming to see you about?

DR. CATHERINE BAST: General family medicine concerns. Acute care, long-term illness, post hospitalization. And then when it became -- and then trans care.

Q You mentioned northern Indiana. I just want to make sure I know, where is Mosaic located?

DR. CATHERINE BAST: We're in Goshen.

Q Have you ever had that -- has it ever been in a different location?

DR. CATHERINE BAST: No.

Q Any satellite clinics?

DR. CATHERINE BAST: No.

Q So the term "gender-affirming care" I think has come up. This is where it gets a little confusing, and I apologize. It was mentioned in Mixhi's declaration, but I think this fits within paragraphs 1 and 2 of the attachment, so I think you're the designee to talk about it.

DR. CATHERINE BAST: Uh-huh.

Q All I wanted to know is this term "gender-affirming care," what it means to you and what Mosaic

Page 26

provides under that kind of rubric.

DR. CATHERINE BAST: So gender-affirming care is human-affirming care. It's being sensitive to the gender that people are as well as the gender that people identify as. Gender-affirming care involves calling people by a name that they choose and by referring to them by the pronouns that they choose. There are medical procedures that fall under gender-affirming care, but those are not the sole purpose of gender-affirming care.

Q Okay. I think I'm following you. Let me get at this a slightly different way. What is the scope of Mosaic's practice outside of the gender-affirming treatments that you mentioned?

DR. CATHERINE BAST: We're a family practice office. We do not do OB anymore, but beyond that, we are a full scope family medicine clinic.

Q And so if I understand you correctly, you're trying to use the gender-affirming care principles even when people come to see you for treatments or problems that are not related to gender or transition or anything?

DR. CATHERINE BAST: Yes.

Q Okay. Do you provide mental health services?

DR. CATHERINE BAST: We do, yes.

Page 27

Q What mental health services do you provide?

DR. CATHERINE BAST: Well, all three of our providers are trained and within their scope can do basic mental health medications as well as triage for mental health issues. We also have a mental health counselor.

Q What -- you mentioned the three providers. Let's identify who those are and what their qualifications are.

DR. CATHERINE BAST: So I'm one, and I'm a family -- board certified family physician, and then we have two advanced practice nurses, family nurse practitioners who also work in our space.

Q And they are, again, you described all three of you as having the capacity to do some mental health services. Are you more qualified to provide mental health services than the certified nurse practitioners?

DR. CATHERINE BAST: No, basic mental health services fall within the scope of family nurse practitioner too.

Q Okay. Do you provide counseling for patients who present with gender dysphoria?

DR. CATHERINE BAST: Yes.

Q What is that counseling? Just give me -- generally

Page 28

speaking, what does that entail?

DR. CATHERINE BAST: Are you asking me as a provider what counseling I give or are you saying does our mental health counselor give counseling?

Q Well, let's start with you as a provider.

DR. CATHERINE BAST: Okay. So as a provider, as a family physician, it is in my scope to give information and support to everybody and education about clinical issues. So in that context, I give counseling for folks who present with gender dysphoria.

Q And then what about the other practitioners, the nurse practitioners?

DR. CATHERINE BAST: And they do that as well.

Q Okay. So there's really no distinction? I was sensing that maybe you thought there was a distinction there. I just want to make sure there isn't.

DR. CATHERINE BAST: No, we're doing the same work.

Q Okay. Just topically speaking, in terms of the topics that you cover in the context of the counseling, can you tell us a little bit about what topics that go into that?

MR. FALK: And again, Tom, are you asking her

Page 29

personally or are you asking about the mental health practitioner or are you asking about all of them together?

MR. FISHER: Well, I would assume it's all the same.

Q But let's start with you, Doctor, and then we can move to the others if we need to.

DR. CATHERINE BAST: So we talk about what gender dysphoria is. We talk about what the treatment for gender dysphoria is. We talk about -- I think that sums it up.

Q And then what about the mental health counselors, do they talk about anything else?

DR. CATHERINE BAST: I'm not privy to their -- we have one mental health counselor, and I'm not privy to what goes on in their individual sessions.

Q And I think I was confused. I think I was thinking that your practitioners, nurse practitioners, and you were mental health counselors, but you're telling me there's a separate person who's a mental health counselor?

DR. CATHERINE BAST: Correct.

Q Okay. Thank you. I finally got that figured out. Tell me about the mental health counselor. What qualification, what role?

Page 30

DR. CATHERINE BAST: She's an LMHC, a licensed mental health counselor, and she is -- has a practice that falls under the umbrella of Mosaic. So she sees about 20 clients a week for counseling, mental health counseling.

Q What counseling services does she provide?

DR. CATHERINE BAST: Again, I'm not privy to their one-on-one sessions, but it's basically support and therapy.

Q What kind of therapy?

DR. CATHERINE BAST: Cognitive behavioral therapy.

Q Is there a -- does the counselor have the authority to prescribe medications for mental health problems?

DR. CATHERINE BAST: No.

Q Is the mental health counseling -- is that practice a successful practice?

DR. CATHERINE BAST: I guess I don't know what you mean by that.

Q Well, are you happy with how it's going for the mental health counselor, positive results?

DR. CATHERINE BAST: I'm not privy to what goes on in their one-on-one sessions, but she is very happy.

Page 31

Q Okay, good. What volume of Mosaic's business would you say is transgender patients?

DR. CATHERINE BAST: We have a patient -- I would say about a quarter. We have a patient panel of around 4,000 and 1,200 trans and nonbinary patients.

Q Okay. And then within the -- that set, that one-quarter set, roughly what percent are transgender minors?

DR. CATHERINE BAST: Only a hundred of those. Around a hundred of those, yeah. So whatever that percent is.

Q I'm not trying to do the math too.

MR. FALK: I know it wasn't a hundred percent, so ...

Q How much annual revenue does Mosaic generate from providing gender-affirming care to minors?

DR. CATHERINE BAST: We have no idea.

Q Mixhi, is that true, you don't know either?

MIXHI MARQUIS: No, I don't know.

Q Overall, does Mosaic treat more children and adolescents or more adults?

DR. CATHERINE BAST: More adults.

Q And then -- yeah, within the context of gender transition procedures -- well, maybe we should actually define that.

Gender transition procedures is probably a term that you don't -- that I think you probably don't like. It's what the statute uses, and I'm using it just because that's what the statute uses. Do you have an understanding of what I mean when I say "gender transition procedures"?

DR. CATHERINE BAST: Yes.

Q So within that scope of treatment, does Mosaic --

MR. FALK: Tom, I'm sorry, I'm just going to object for one second. Even though she says she understands, I'd appreciate it, for the record, if you would define for her what those are.

MR. FISHER: Oh, yes. That's fine.

Q Let's go --

MR. FISHER: We're going to take this a little bit out of order, Shawn, I'm so sorry. But one of the exhibits is Senate Enrolled Act 480. So let's go ahead and mark that, and we'll make this a little bit easier.

SHAWN WEYERBACHER: What's that exhibit number?

MR. FISHER: Razi? Do you have that, Razi?

MR. LANE: 9. It's Exhibit 9.

(Deposition Exhibit 9 marked.)

Page 32

Page 33

Q Okay. Dr. Bast, have you seen this document before?

DR. CATHERINE BAST: Yes.

Q Okay. So this is the statute, the newly enacted statute, that you are suing to have declared unconstitutional; is that right?

DR. CATHERINE BAST: Yes.

Q Okay. So if we turn to page 2, under Section 5. I don't know if you can read that or if you've got it in front of you, either way. It says under Section 5(a), it says, "gender transition procedures," and then it goes on to define what that means. I don't want to read the whole thing because it is kind of long. But it's 5(a)(1) and (2), and then it goes into (b).

Is this something that you're familiar with?

DR. CATHERINE BAST: Yes.

Q So when I say "gender transition procedures," this is what I'm talking about.

DR. CATHERINE BAST: Uh-huh.

Q Okay, great.

So within that --

MR. FISHER: Shawn, I think we can take that down now.

Q Unless, Doctor, you need it up on the screen.

Page 34

DR. CATHERINE BAST: No, that would be okay.

Q Within the definition of gender transition procedures, does Mosaic treat more female-to-male transitioners or more male-to-female transitioners?

DR. CATHERINE BAST: I don't have an answer to that.

Q And Mixhi, I just want to confirm, do you have an answer to that?

MIXHI MARQUIS: I don't know that either.

Q So, Dr. Bast, please describe for me, I think you mentioned the WPATH guidelines, but I would like for you just to give us kind of an overview of Mosaic's protocols, standards, guidelines, policies for diagnosing gender dysphoria in minors.

DR. CATHERINE BAST: So according to the WPATH standards, gender dysphoria is defined as marked emotional and distress related to an incongruence between the sex assigned at birth and somebody's gender identity. And the DSM-5 says that gender dysphoria needs to be present for at least six months. So that that dysphoria is there at least for six months.

Q Okay. Anything else?

DR. CATHERINE BAST: So maybe you want to go back to your question again.

Page 35

Q My question was just, what, you know, protocols, guidelines, policies, whatever it is that informs how you diagnose gender dysphoria in minors.

DR. CATHERINE BAST: So the WPATH also -- I follow the WPATH standards, and I have since the beginning of Mosaic. And updated them as the WPATH standards were updated. But WPATH recommends a biopsychosocial eval and also that somebody with experience in dealing with folks with gender dysphoria do a diagnosis, which fits the definition from the DSM-5 that I said before. And so that's what we follow at Mosaic.

Q Okay. Why do you follow the WPATH guidelines?

DR. CATHERINE BAST: I trained with them. I did my training with them, and they are the broadest and most widely applied standards in this work.

Q Are you familiar with the Endocrine Society guidelines?

DR. CATHERINE BAST: I am, yes.

Q Is there a material difference between the two?

DR. CATHERINE BAST: To the best of my knowledge, the only difference is that moving from diagnosis to treatment, the Endocrine Society recommends that a pediatric endocrinologist confirm

Page 36

the necessity of treatment.

Q WPATH doesn't recommend that?

DR. CATHERINE BAST: No.

Q Well, why do you -- and you follow the WPATH, not the Endocrine Society, including on that point?

DR. CATHERINE BAST: Correct.

Q Why do you think that the Endocrine Society is wrong?

MR. FALK: Objection. That's not what she said.

Q Do you think the Endocrine Society is wrong?

DR. CATHERINE BAST: No, but I think WPATH accounts for the lack of availability of pediatric endocrinologists and recognizes the possibility that other providers could be equally capable and authorized to prescribe treatment even without the blessing of a pediatric endocrinologist.

Q So you don't think a pediatric endocrinologist is necessary?

DR. CATHERINE BAST: I believe that it is fully within my scope as a family physician to make the diagnosis of gender dysphoria and to provide treatment.

Q Is there any scientific basis for your conclusion in that regard?

Page 37

DR. CATHERINE BAST: I don't know.
Q Would you describe the WPATH standards as flexible?
DR. CATHERINE BAST: What do you mean by "flexible"?
Q Well, do you adhere to every standard, every, I guess, rule or guideline to the letter or do you say sometimes, well, I see that's a guideline that's not met here, but I think it's not important, so we'll just not consider that?
DR. CATHERINE BAST: WPATH is very clear in its standards that this care is individualized and takes into account the individual needs. And so I treat the person in front of me following those guidelines.
Q Can you think of a circumstance -- and I don't need you to name names or anything -- I'm just thinking about is there a circumstance where you would think, you know what, the WPATH guideline here is not something that I should follow for this particular person with gender dysphoria?
DR. CATHERINE BAST: No, I follow -- I can't think of an instance.
Q Okay. Let's move on to the complaint.
MR. FISHER: Shawn, I'm not sure what exhibit we're up to. This is, I think, 8.

Page 38

(Deposition Exhibit 8 marked.)
Q Doctor, are you familiar with this document?
DR. CATHERINE BAST: Yes.
Q Can you just describe what it is for the record, please.
DR. CATHERINE BAST: This is the complaint that was submitted to -- in the lawsuit in objection to SEA 480.
Q Have you read this complaint before?
DR. CATHERINE BAST: Yes.
Q While we're on this subject, Mixhi, I just would like to get your answer to the same question. Have you read this complaint before?
MIXHI MARQUIS: Yes.
Q So this -- again, this is the lawsuit, this is the complaint to start the lawsuit challenging Exhibit 9, which is SEA 480, which we looked at a minute ago. And I just want to make sure I've got -- that I'm clear about this.
Mixhi, you testified nobody from Mosaic testified at the legislative hearings over SEA 480; correct?
MIXHI MARQUIS: Yes, that's correct.
Q And Dr. Bast, is that your understanding as well?
DR. CATHERINE BAST: Yes.

Page 39

Q Okay. Now, with respect to this lawsuit, you'll see there at the top there's all the names in the case caption, one of which is M.R., which is, as I understand it, a patient that you're treating, Dr. Bast; is that correct?
DR. CATHERINE BAST: Yes.
Q And I'm wondering, do you know anybody else in -- that's a plaintiff in the lawsuit besides M.R.?
DR. CATHERINE BAST: No.
MR. FALK: I'll just interpose a comment or objection. There may be client meetings subsequent to the filing of the case. I think the doctor was asking -- answering the question as if you asked if she knew anyone before the lawsuit was filed. So if you want to rephrase the question or if you understand that to be her answer, that's fine. I just wanted to clear that up.
MR. FISHER: No, I think we've got what we need. That's fine. Thanks, Ken.
Q Okay. So now, Dr. Bast, I'm going to ask you questions a little more generally. We've touched on this a little bit, but I just need to have a better understanding of how you think about some of the terminology and the issues in the case.
What is your understanding of a person's sex?

Page 40

What does that mean?
DR. CATHERINE BAST: A person's sex is an assignment that is complex that involves multiple systems, including genitalia, genetics, and variations within -- with hormonal function. So a sex is assigned typically by a visual inspection at birth.
MR. FISHER: And Shawn, we can take the exhibit off. We don't need that right now. Thanks.
Q Doctor, can a human being's sex be accurately identified using objective information?
DR. CATHERINE BAST: Possibly.
Q Okay. Can you elaborate, please, what you mean by that.
DR. CATHERINE BAST: Sex is a complex assignment and includes multiple systems, not all of which may -- may be objectively assessed in a given moment.
Q Okay. So what's something that may not be objectively assessed in a given moment that's relative to sex?
DR. CATHERINE BAST: If a person has a genetic disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome, that is not able

Page 41

to be assessed at the moment -- necessarily at the moment of birth.

Q Oh, I'm not necessarily talking about at the moment of birth. I just mean through objective information at any -- at any given time. When you have access to that objective information. If you have access to objective information about all of those relevant systems, can you, using only that objective information, accurately deduce someone's sex?

DR. CATHERINE BAST: Not for all humans. Not all humans are objectively able to be categorized.

Q Okay. So what humans are not?

DR. CATHERINE BAST: Well, there are some humans born intersex. So born with chromosomal abnormalities that don't necessarily match up with XX or XY, which are traditionally associated with assigning female and assigning male.

Q Anyone else?

DR. CATHERINE BAST: That's all.

Q If we set aside those with those abnormalities for the sake of this discussion, is sex fluid?

DR. CATHERINE BAST: No.

Q Is sex relevant to the practice of medicine?

DR. CATHERINE BAST: Yes.

Page 42

Q Is sex relevant to health?

DR. CATHERINE BAST: No.

Q How is sex relevant to the practice of medicine but not relevant to health?

DR. CATHERINE BAST: We use the designation of sex as an overarching term that describes a number of different body formations. Different bodies have different organs. Different organs need different care. So in that sense, sex is important in the practice of medicine.

Q But not to health?

DR. CATHERINE BAST: When I use the word "health," I am thinking very broadly about well-being. And certainly if there is disease or dysfunction in any of the organs that a body has, those need to be -- well, often need to be treated in order for a person to feel -- to have a sense of well-being. But a person's sense of well-being is much broader than their sex.

Q I'm not asking if it's the only thing. I'm just asking if sex is relevant to health.

DR. CATHERINE BAST: Sex is relevant to health in that sense, in the sense -- yeah, in the sense of the organs, uh-huh.

Q Okay. So describe to me how you understand a person's gender identity.

DR. CATHERINE BAST: So a person's gender identity is the way they experience gender. And gender is a complex construct because in our culture we associate particular -- there's a context for each -- for the different sexes that we identify. So gender identity is how a person feels about who they are, what their gender is.

Q I think you said "our culture." I don't mean to put words in your mouth. But did you say "our culture"?

DR. CATHERINE BAST: Any culture has gender associations. Our culture does too.

Q So the -- I want to make sure I understand. When you are thinking about gender and gender identity as it relates to culture, does that have any kind of geographic limitation or cultural limitation at all or does it assume every culture in the world?

DR. CATHERINE BAST: I don't know every culture in the world, so I'm talking from my context.

Q Okay.

MR. FALK: Hey, Tom, I'm going to interrupt. It's been about an hour. Can we have a break in a little bit?

Page 44

MR. FISHER: Yeah, one second here. You know what, good enough place to break right now. That's fine.

MR. FALK: Great.

MR. FISHER: Five minutes, is that enough or do you need more?

MR. FALK: Five is good. Thanks.

(Recess taken.)

BY MR. FISHER:

Q Doctor, we were talking about gender identity, what that means in your view, and so I just want to pick up there, kind of ask a few more questions.

Does gender or can gender identity change over time?

DR. CATHERINE BAST: Yes.

Q How often can it change?

DR. CATHERINE BAST: I don't know.

Q Have you seen any patients where it has changed over time?

DR. CATHERINE BAST: One.

Q And what were the circumstances of that patient?

DR. CATHERINE BAST: That person came to Mosaic as an adult identifying as assigned female at birth, identifying as a male, and then later on, about four years later, did not identify that way

Page 45

anymore.
Q And you treated that person?
DR. CATHERINE BAST: I did.
Q And what sorts of treatments did you provide?
DR. CATHERINE BAST: So are we -- this is an adult.
Q Sure.
DR. CATHERINE BAST: Testosterone.
Q Anything else?
DR. CATHERINE BAST: I provided a referral for top surgery.
Q What is top surgery?
DR. CATHERINE BAST: Top surgery is a chest reconstructive surgery to make -- to remove breast tissue and to make the chest look more masculine.
Q Is that different from a bilateral mastectomy?
DR. CATHERINE BAST: I don't -- I don't understand the surgical differences, but I understand from surgeons that, yes, it is different.
Q But you don't know exactly how?
DR. CATHERINE BAST: No.
Q Do you know if that patient had gone through with the top surgery?
DR. CATHERINE BAST: I believe they did.

Page 46

Q But then later ceased identifying as male?
DR. CATHERINE BAST: Correct.
Q Did you treat the patient after that, I guess, what everyone calls a decision or assessment or whatever it is that -- where the identification as male had stopped and the identification was then female?
DR. CATHERINE BAST: They saw me in the office after that, yes.
Q What was the attitude towards the surgery at that point?
DR. CATHERINE BAST: As I recall, they -- they didn't -- they weren't happy with the results of the surgery.
Q So you had the one patient, but as I understand it, you acknowledge gender identity can change over time, just -- am I right about that? Did I say that right?
DR. CATHERINE BAST: I think it's possible that gender identity can change over time.
Q Okay. What's your basis for saying that?
DR. CATHERINE BAST: Experience.
Q Yet you've only had one patient where gender identity changed over time. Is that the sum total of the experience that informs that assessment?
DR. CATHERINE BAST: Yes.

Page 47

Q Do you have any idea what that -- for that one patient what caused the gender identity to change?
MR. FALK: And, Tom, I'm just going to interpose an objection just for the record. Obviously this is a deposition. But I just want to reemphasize, this was an adult person, not a child and, therefore, has nothing to do with our litigation.
Having said that, ask away. But I just wanted to make sure that the record is clear in that regard.
Q I'm sorry, do you want me to restate the question or --
DR. CATHERINE BAST: Yes, please.
Q I was wondering if with respect to that one patient if you knew what caused gender identity to change.
DR. CATHERINE BAST: No, I don't.
Q When it comes to assessments of gender identity and the treatments available for gender dysphoria and the experiences of patients, do you think adults and children are different?
DR. CATHERINE BAST: Could you ask that again in another way?
Q Well, really I'm just -- I'm just hearkening back to Mr. Falk's objection and to your observation

Page 48

earlier about we're talking about an adult and this lawsuit is about children. And I'm just wondering from your perspective why that matters.
DR. CATHERINE BAST: Well, right now what we're arguing is over youth and not over adults.
Q But why does that matter? That's my question.
DR. CATHERINE BAST: In my experience of interacting with trans individuals, the experience of gender dysphoria is something that I hear -- for the experience of gender dysphoria is something that children experience and also adults experience.
Q So there is no difference?
MR. FALK: Again, Tom, there is no difference as to what?
DR. CATHERINE BAST: Yeah, as to?
Q As to the experience of gender dysphoria between children and adults.
MR. FALK: And I guess I'll just interpose an objection. She is not being qualified as an expert. She can certainly testify from her experience. But she can give a general statement as to -- based on expertise.
And also I would also -- when we use the term "children," as you know, there is a distinction

Page 49

regarding gender dysphoria treatment of transgender persons under the age of 18 between children and adolescents. So I just want to make sure the record is clear what is being asked and answered.

DR. CATHERINE BAST: In my experience as a clinician, I have had people of all ages, from age three on, describe to me experiences of gender dysphoria.

Q And? I'm still wondering, what -- is there a difference, when it's a child, whether it's 3, 6, 9, 12, 15, 18, is there a difference between children and adolescents compared with adults when it comes to diagnosing and treating gender dysphoria?

DR. CATHERINE BAST: So the diagnosis of gender dysphoria is the same according to the DSM and WPATH of gender dysphoria in children, adolescents, and adults.

MR. FISHER: So when you say it's possible for gender identity to change based on your experience with that one patient, does that conclusion apply equally to those under the age of 18 who have gender dysphoria?

DR. CATHERINE BAST: To the best of my knowledge, the data, as we currently know it, is

Page 50

that very few children and adolescents, particularly adolescents, by the time they reach adolescence, very few change, have a change in gender identity post adolescence.

Q But some do?

DR. CATHERINE BAST: Very few. I don't know what the number is, but very few.

Q One thing that I'm wondering about, how we use our terminology here. Is being transgender, that -- whatever that means, is it the same as having a gender identity? Is transgender a gender identity or are those not -- is that not the way to talk about it?

DR. CATHERINE BAST: Technically a trans person is somebody who does not identify as the way they were assigned at birth. And a cis person is somebody who identifies the same way they were assigned at birth.

Q So if someone says -- and let's suppose you don't know -- there's written correspondence, you're not in the room with the person, you have nothing to observe, but the person says to you, I'm transgender, then do you know that person's gender identity at that moment?

DR. CATHERINE BAST: No, all I know is that

Page 51

they don't identify the same as they were assigned at birth.

Q And how do you know if someone is transgender?

DR. CATHERINE BAST: They tell me.

Q Is there any way to observe through objective evidence whether someone is transgender?

DR. CATHERINE BAST: No.

Q Can someone be transgender but not have gender dysphoria?

DR. CATHERINE BAST: Not in my experience.

Q What is the error rate in diagnosing gender dysphoria?

DR. CATHERINE BAST: I don't know.

Q Have you ever encountered any publications that discuss the error rate of diagnosing gender dysphoria?

DR. CATHERINE BAST: No.

Q Are you aware of any way to look at data or run tests that would tell you about the error rate for diagnosing gender dysphoria?

DR. CATHERINE BAST: No.

Q Is it theoretically possible that gender dysphoria could be erroneously diagnosed?

MR. FALK: And again, I guess I'll object, just insofar as you're asking an expert question of

Page 52

someone who is not an expert. She can testify from her experience.

DR. CATHERINE BAST: So do you want to go back to your question? Sorry, I got distracted by Ken.

Q Of course, sorry.
I'm wondering if it's -- in your estimation, is it theoretically possible to erroneously diagnose gender dysphoria?

DR. CATHERINE BAST: Not in my experience.

Q It's not possible?

MR. FALK: Again, she answered as to her experience because she's not an expert. So whether it's possible or not I think is beyond her ability since she's not qualified -- here being qualified as an expert. She can talk about her experience, which she did.

Q Doctor, anything to add?

DR. CATHERINE BAST: (Negative shake.)

Q Do you worry about erroneous diagnoses in any aspect of your practice?

DR. CATHERINE BAST: Certainly.

Q Such as? What's an example?

DR. CATHERINE BAST: Well, I -- for example, somebody with diabetes. I'm concerned that if somebody is diagnosed with type 2 diabetes that it

Page 53

may, in fact, be type 1 diabetes.
Q Have you misdiagnosed someone with type 2 diabetes when, in fact, it was type 1?
MR. FALK: And I guess I'll object to that question, since you're asking her possibly if she committed a medical error in an unrelated case to this. And I guess I'll instruct her not to answer, Tom, just because I don't want her opening herself up to questions of practice competence on other issues.
MR. FISHER: I'm not aware of a privilege that applies here, Ken.
MR. FALK: Yeah, I'm not aware of a privilege either. However, this is so far afield, and you're asking a professional to answer whether she's ever committed a mistake in diagnoses in previous cases. And I don't see how it's possibly relevant to this. She testified to the fact that she obviously is always concerned about errors and making proper diagnoses.
If you want to certify the question, you can. I just don't think it's appropriate. I can't imagine a lawyer being asked, have you ever made a mistake in a situation where that might hold themselves out for malpractice. I just don't think

Page 54

it's -- it's so far afield. I'm just going to object. I apologize, but I just ...
MR. FISHER: No, fair enough. I'm not interested in having a side battle here. I'm just trying to get a -- kind of how one goes about a practice when it comes to diagnosing gender dysphoria.
BY MR. FISHER:
Q Doctor, let me try this a different way. You worry about the prospect of misdiagnosis in other contexts besides gender dysphoria; is that fair to say?
DR. CATHERINE BAST: I'm sorry, say it again. I worry about?
Q The prospect of misdiagnosis in areas of your practice other than with respect to gender dysphoria. The type 1/type 2 diabetes is the example that you gave, and I'm just trying to get a reaffirmation. You understand it is possible for doctors to make mistakes when they diagnose something; is that fair to say?
DR. CATHERINE BAST: It is possible.
Q Yeah. And is that true regardless whether the doctor has ever made that mistake before? Does a doctor, nonetheless, recognize that in the future,

Page 55

regardless that there have been no mistakes in the past, that it's possible to have a misdiagnosis?
DR. CATHERINE BAST: No diagnosis is perfect in medicine a hundred percent of the time all the time.
Q Okay. So you take that into the context of diagnosing gender dysphoria, then; is that correct?
DR. CATHERINE BAST: The difference with gender dysphoria is that the diagnosis itself requires a six-month period. So gender dysphoria, in order to be given the diagnosis, you need to have demonstrated distress and about gender incongruence for at least six months, which is not the same as the example I gave for diabetes.
Q So that's -- oh, sorry. I didn't mean to interrupt.
DR. CATHERINE BAST: I think the time frame makes it less likely that there will be a misdiagnosis.
Q Fair enough. Does it eliminate the possibility of misdiagnosis?
DR. CATHERINE BAST: No.
Q Another terminological issue I'd like to sort out, just because I've run across these terms and I want to make sure I understand a little bit better what

Page 56

I'm talking about. Is there a difference between gender dysphoria or gender incongruence, or are those two different ways of saying the same thing?
DR. CATHERINE BAST: Gender incongruence refers to the difference between what's assigned at birth and the identity. Gender dysphoria is a diagnosis of the distress over that gender incongruence.
Q Okay. So is gender incongruence then the same as being transgender?
DR. CATHERINE BAST: People who are transgender have gender incongruence, yes.
Q I mean, is it a hundred percent overlap or are they just two different terms for the same thing?
DR. CATHERINE BAST: I think they're the same.
Q With respect to minors, how do you diagnose a minor with gender dysphoria?
DR. CATHERINE BAST: According to the DSM diagnosis, so --
Q I'm really -- and I'm sorry to interrupt. I really just mean, practically speaking, within your practice, how do you do it?
MR. FALK: And Tom, are you -- when you say minor, do you mean anyone under the age of 18? Do you mean an adolescent or child since the --

Page 57

there's some differences, or do you want to --
MR. FISHER: Well, let's start with the broad question.
Q Are there differences in how you approach the diagnosis depending on the age of the minor?
DR. CATHERINE BAST: No. The diagnosis remains the same. I rely on the patient and often the patient's parents to help me understand -- to demonstrate the dysphoria and the length of time.
Q I see. Is that then according to the methods set forth in the DSM-5?
DR. CATHERINE BAST: Is what?
Q I'm sorry, your method for diagnosis.
DR. CATHERINE BAST: No, my method for diagnosis is to collect data necessary to give the diagnosis.
Q Okay. What is the data necessary?
DR. CATHERINE BAST: What the patient and the family tell me.
Q About what?
DR. CATHERINE BAST: About the patient's gender dysphoria.
Q Well, I guess that's my question is what is it that you're asking that gets at the issue of gender dysphoria? What information, what data points are

Page 58

you looking for?
DR. CATHERINE BAST: In my experience, patients come to me ready to tell me that they have experienced dysphoria with the sex they were assigned at birth. So I'm listening to their story.
Q But when they tell you their story, what information are you trying to learn that helps you make a diagnosis?
DR. CATHERINE BAST: I'm learning -- I'm asking or I'm looking for their experience of distress and their experience of not being -- their gender identity not being congruent to the one they were assigned at birth.
Q What are some examples?
DR. CATHERINE BAST: I can -- in my experience, I have children and parents who come into the office and say -- give me a name of a child and say, this child was assigned this at birth, but they have wanted and expressed and repeatedly said that they are not the gender that they were assigned at birth and have, in fact, expressed very clearly that they are -- so yeah, that they are different from the gender they were assigned at birth.

Page 59

Q Anything else?
DR. CATHERINE BAST: I think that's all I want to say.
Q Well, I mean, I guess part of what I'm wondering is do you have a sense of what that means to the minor when they say that?
DR. CATHERINE BAST: In my experience, I have children who come in really distressed and tell me emphatically who they are and what their gender identity is.
Q Are there any common traits that they are seeking or are troubled by?
DR. CATHERINE BAST: I don't understand the question.
Q Do you ask the -- when a minor comes in and says, I strongly feel I am not my natal sex, that I am -- my gender identity is opposite my natal sex, do you ask follow-up questions?
DR. CATHERINE BAST: Certainly.
Q What are those questions?
DR. CATHERINE BAST: Can you tell me more about that? Can you please tell me what -- explain that more to me. Talk to me about how you experience your gender.
Q And what are you looking for in those answers?

Page 60

DR. CATHERINE BAST: I am looking for a demonstration of their distress and their gender incongruence lasting longer than six months.
Q What would amount to such a demonstration?
DR. CATHERINE BAST: It really varies from patient to patient.
Q How do you know when you've got enough information to make the diagnosis?
DR. CATHERINE BAST: When I -- when I hear evidence of marked distress, of distress that lasts -- in their gender identity and hearing the stress around gender incongruence longer -- lasting longer than six months, then I have enough to make a diagnosis.
Q Do you ask anything more specific than, tell me about your feelings of gender dysphoria?
DR. CATHERINE BAST: No.
Q How do you measure the level of distress that the minor presents with?
DR. CATHERINE BAST: I don't have a measure.
Q Do you ever wonder if the patients have another cause for their expressed distress that is not where gender dysphoria, gender incongruence, is not the source?
DR. CATHERINE BAST: It's pretty clear if

Page 61

somebody has gender incongruence when they're -- if they're expressing that they don't identify as the sex they were assigned at birth.

Q Do you ever try to rule out other causes of their distress?

DR. CATHERINE BAST: Certainly I'm treating the patient in the context, and I treat the whole person. I'm a family doctor. So certainly if there are other sources of distress for a patient, we want to address those as well.

Q How do you -- how do you know if it's those other sources versus the gender incongruence that's causing the claim of gender dysphoria?

DR. CATHERINE BAST: I can only go by what the patient and the family tell me.

Q How do you know if a given treatment is, quote/unquote, medically necessary? And I'm quoting it because it's in paragraph 12 of your declaration. If you could turn to that, actually, maybe that's a better way to do it.

MR. FISHER: Shawn, can we put -- I'm not sure which one this is. This is the declaration of Dr. Catherine Bast.

MR. FALK: 7.

MR. FISHER: 7, thank you.

Page 62

SHAWN WEYERBACHER: One second.

Q So let's turn to paragraph 12. Doctor, can you see it or do you have it in front of you, paragraph 12?

DR. CATHERINE BAST: I have it in front of me, uh-huh.

Q Okay, great. So it says, "The puberty-blocking drugs and gender-affirming hormones are provided only where it is medically necessary to do so." And I'm wondering how you know when it's medically necessary to do so.

DR. CATHERINE BAST: Well, there are standards and guidelines for treatment so that -- that I follow. So puberty-blocking drugs, for example, would be medically necessary in someone experiencing gender dysphoria who is prepubescent and just starting into puberty, up to Tanner stage 2. So then it would be medically necessary to alleviate this person's distress by providing puberty-blocking drugs so that they do not undergo the puberty that's not associated with their gender identity.

Q And hormones?

DR. CATHERINE BAST: And hormones are necessary when somebody has already been through puberty but has gender dysphoria and their body

Page 63

does not match the gender that they identify with. And so hormones are used to help redress that balance and change the body to reflect their gender identity.

Q So is it fair to say -- and I don't mean to put words in your mouth, I just want to make sure I've got this. Is it fair to say that once there's a diagnosis of gender dysphoria, what's medically necessary then really turns on the age and the relationship to Tanner stage 2? Before Tanner stage 2, it's blockers; if it's after Tanner stage 2, it's hormones?

DR. CATHERINE BAST: That sounds correct, yes.

Q What do you do to ensure informed consent among -- when it's a minor? I'm still speaking here of minors. When it's a minor and you're prescribing a course of treatment, what do you do to ensure you have obtained informed consent?

DR. CATHERINE BAST: I have a long and thorough discussion with the patient, as well as a parent or guardian, about the nature of the treatment, the potential risks and the potential benefits of the treatment. I answer any questions that they may have.

Q All right. Let's -- I think we've got -- are we up

Page 64

to Exhibit 10 now? Informed consent for balancing hormones; do we have that document? There we go.

MR. FISHER: This is 10, I think. Am I right about that?

MR. FALK: Correct.

MR. FISHER: Razi is nodding his head. Good.

(Deposition Exhibit 10 marked.)

Q Doctor, can you tell me what this document is?

DR. CATHERINE BAST: Yes, this is a document that we provide to folks who are thinking about puberty blockers that has a summary of things that we want to touch on in our discussions about getting informed consent for this procedure.

Q And then -- so we're talking here about children before Tanner stage 2?

DR. CATHERINE BAST: Correct.

Q Any other universe of patients where this would be relevant?

DR. CATHERINE BAST: This treatment is also used for central precocious puberty.

Q Do you use the same form in that context?

DR. CATHERINE BAST: Yes. Oh, wait. Yeah.

Q And we're going to come back to that, but for now I want to move to Exhibit 11, which is another consent form. It says Consent for Hormonal

Page 65

Suppression.
(Deposition Exhibit 11 marked.)
Q Doctor, what is this document?
DR. CATHERINE BAST: This is a precursor document to the one that we just saw.
Q What do you mean by that?
DR. CATHERINE BAST: I mean that this was developed for a capstone project that I did in residency and not intended to be used necessarily as something to give to patients. But it informed -- it informed the one that we used to give to patients.
Q I see.
(Deposition Exhibit 12 marked.)
Q All right. Let's go to 12, Exhibit 12, Transitioning Informed Consent Document.
Doctor, what is this? I'm sorry, go ahead.
DR. CATHERINE BAST: This is also a previous information document that was developed -- that I developed at the end of my residency as part of my capstone project.
Q Is this a document that you use in your practice now?
DR. CATHERINE BAST: No.
Q No?

Page 66

MR. FALK: Can we go off the record for a second?
MR. FISHER: Sure.
(Discussion held off the record.)
BY MR. FISHER:
Q So let's go ahead and mark the next -- bring up the next one, which is -- I'm sorry, what are we up to, 13, the one that says Testosterone?
(Deposition Exhibit 13 marked.)
Q There again, Doctor, just go ahead and tell me what this is.
DR. CATHERINE BAST: Well, this is the document, again, that was developed as part of my capstone project in residency as -- and this is used as a guide for the documents that we use now.
Q I see. Is there anything in the -- for lack of a better term, the capstone documents, is there anything -- notwithstanding you don't use them now, but is there anything in them that you think is incorrect or no longer relevant or inaccurate, anything like that?
DR. CATHERINE BAST: I would have to review them again. I don't know.
Q All right. Do you -- when you have a patient that you're treating with, let's -- actually, it doesn't

Page 67

matter, either with gender blockers or with hormones, and we're talking about minors here, do you monitor the efficacy of the medications?
DR. CATHERINE BAST: Yes.
MR. FISHER: Oh, Shawn, we can take the exhibit off, I think, for now.
Q How do you do that? How do you monitor?
DR. CATHERINE BAST: There are different protocols for each treatment.
Q Okay. Let's start with puberty blockers. What's the protocol there?
DR. CATHERINE BAST: With puberty blockers, we are monitoring to be sure that puberty is not ongoing. So we're making sure that they are not continuing to develop signs and symptoms of puberty. We are monitoring their height and their weight, and we're also monitoring their level of satisfaction with the treatment.
Q How do you know if a given -- if the puberty-blocking treatment is working?
DR. CATHERINE BAST: If the puberty-blocking treatment is working, then they are not developing any secondary sex characteristics associated with the hormone -- the dominant hormone that their organs would produce if they weren't on the

Page 68

blockers.
Q Anything else?
DR. CATHERINE BAST: No.
Q How often do you follow up with patients on puberty blockers?
DR. CATHERINE BAST: Every three months, at least, in the first year. If things are going well and there haven't been any -- yeah, if everything seems to be going well, we can space that out to every six months.
Q And then what about hormones, again, how do you monitor the efficacy?
DR. CATHERINE BAST: So we're looking for development of secondary sex characteristics that are affected by the hormone that we're giving. We are also monitoring their level of satisfaction with the treatment. And every three months we are checking labs.
Q What are you checking the labs for?
DR. CATHERINE BAST: Hormone levels, and also we're checking to see if there have been any sequelae from the hormones that sometimes can appear in -- that are only visible in blood work.
Q Sequela such as?
DR. CATHERINE BAST: Such as somebody that's

Page 69

on estrogen, they're likely to have a hemoglobin that goes down, which is normal for folks whose dominant hormone is estrogen. So we're monitoring that.

Q Any other sequelae that you monitor?

DR. CATHERINE BAST: We are monitoring also the hemoglobin conversely, the hemoglobin rising in folks who are on testosterone.

Q How often do you follow up with the patients on hormones?

DR. CATHERINE BAST: Every three months.

Q Until forever or --

DR. CATHERINE BAST: Until things are -- within the first year. And then if -- after the first year we can space it out to every six months.

Q And those -- every six months follow-up continues for the rest of their lives?

DR. CATHERINE BAST: Eventually, if things seem fine and the levels are -- and all the labs are normal and the dosing is correct, then we can see them once a year.

Q Once a year for the rest of their lives?

DR. CATHERINE BAST: Yes.

Q In your experience, do most patients stick with those follow-up appointments?

Page 70

DR. CATHERINE BAST: Yes.

Q Any that don't?

DR. CATHERINE BAST: Very few.

Q So with the hormones, how do you know that that treatment is working?

DR. CATHERINE BAST: Well, the body of the patient is changing to reflect the gender identity that they have. And I'm also engaged with the patient about how they're experiencing the treatment.

Q What does that mean?

DR. CATHERINE BAST: That means I'm asking them how are they feeling with the changes.

Q What kinds of answers are you looking for?

DR. CATHERINE BAST: I'm looking to hear from patients if they are having the changes that they expected and at what rate they're having those changes and how they feel about them.

Q Are you assessing their mental health?

DR. CATHERINE BAST: Yes. I'm a family doctor, so I -- and often these patients are patients that see me as a primary care physician as well. And so we are assessing their whole being, which includes mental health.

Q What specifically do you ask them to get at their mental health?

Page 71

DR. CATHERINE BAST: There are a couple of standard screening questionnaires that are used across the board in medicine to assess for things like depression and anxiety, and sometimes we use those. But often it's just asking. Asking patients to tell me how they are.

Q So you don't always use the standard questionnaires?

DR. CATHERINE BAST: Not always, no.

Q When do you use the standard questionnaires?

DR. CATHERINE BAST: Typically if patients are expressing depression or anxiety, we'll use the questionnaires to characterize that.

Q And then based on the responses you get, what might be the -- I guess your responses as a doctor to those questionnaires?

DR. CATHERINE BAST: So then we need to address the mental health concerns and talk about resources for therapy, talk about the possibility of medications, talk about treating those mental health concerns.

Q You have a mental health counselor at Mosaic; is that right?

DR. CATHERINE BAST: Yes.

Page 72

Q Okay. At what point does that mental health counselor get involved with the diagnosis and treatment of minors who are gender dysphoric?

DR. CATHERINE BAST: What do you mean, at what point?

Q Well, does the mental health counselor ever get involved with the diagnosis and treatment of a minor who presents with gender dysphoria?

DR. CATHERINE BAST: And by getting involved, you mean?

Q Assessing, evaluating, treating.

DR. CATHERINE BAST: She is capable of it. But I wouldn't be able to tell you, of all the patients that we see, how many -- how many she sees and is involved with.

Q Well, I guess -- so it's not every patient, then?

DR. CATHERINE BAST: No.

Q Not every -- and by that, I mean not every minor that presents with gender dysphoria.

DR. CATHERINE BAST: No. What I was saying is that not every patient who comes to Mosaic who is a minor with gender dysphoria sees our mental health counselor.

Q Got you. And what determines whether that patient sees the mental health counselor?

Page 73

DR. CATHERINE BAST: Patient request. Some patients already have a therapist that they're seeing and don't need services of our mental health provider.

Q Do all minors who present with gender dysphoria need services from some mental health provider?

DR. CATHERINE BAST: Need in terms of what?

Q Is it part of your protocol that they must see and be treated by and assessed by a mental health provider?

DR. CATHERINE BAST: No.

MR. FALK: And I was just going to object, but too late now, I guess. But I think at the beginning of this deposition the doctor indicated that as the -- it is within her competence to do basic work in the mental health area with their patients as a family practice doctor. So I assume your question was whether it's a requirement that they see -- be seen by someone other than the medical professionals here.

MR. FISHER: Yes, that's -- that is exactly right, Ken.

Q And so, Doctor, any change in your answer, then, based on that understanding?

DR. CATHERINE BAST: No.

Page 74

Q You mentioned earlier that some children present with precocious puberty that -- for whom you prescribe blockers; is that accurate to say?

DR. CATHERINE BAST: Yes.

Q And do you ever see side effects of the blockers, unwanted side effects?

DR. CATHERINE BAST: No.

Q Do you ever encounter transgender minors who present themselves and decide that they don't want puberty blockers? And I'm talking about pre-Tanner stage 2.

DR. CATHERINE BAST: Well, pre-Tanner stage 2, they're not appropriate.

Q Ah, fair enough. Okay. At Tanner stage 2, then, when they would be appropriate, did you ever have a discussion with them and then they decide, you know what, this isn't for me?

DR. CATHERINE BAST: I have patients who are Tanner stage 2 who are not undergoing puberty blocker treatments, yes.

Q Okay. What -- I guess I'm a little bit surprised. What do you think accounts for that decision?

DR. CATHERINE BAST: It's an individual patient and family decision. And at this point in time there are patients of mine who have opted not to do puberty blockers.

Page 75

Q But they have -- do they have gender dysphoria?

DR. CATHERINE BAST: Yes.

Q And how do you treat the gender dysphoria if they're not taking puberty blockers?

DR. CATHERINE BAST: We're not doing any medical intervention for the gender dysphoria in that case.

Q Is there a mental health intervention?

DR. CATHERINE BAST: If there are mental health concerns, yes.

Q So there might be some gender dysphoric at Tanner stage 2 where they're not doing puberty blockers, but there's also no need for mental health intervention?

DR. CATHERINE BAST: I wouldn't be able to tell you without reviewing the charts.

Q What, in your mind, would be a cause for such a person to seek mental health intervention?

DR. CATHERINE BAST: In such a person, you mean?

Q Gender dysphoric at Tanner stage 2, refusing puberty blockers.

DR. CATHERINE BAST: Well, they could have any -- I think there would be lots of reasons that somebody might want mental health.

Page 76

Q Right. So not all of them -- but not all of them; right?

DR. CATHERINE BAST: I'm sorry, not all?

Q Gender dysphoric at Tanner stage 2 refusing puberty blockers. I think you said some of them might have mental health intervention, but not all of them. Am I right? Is that right?

DR. CATHERINE BAST: That's correct.

Q And what would be the reasons some of them would have mental health intervention?

DR. CATHERINE BAST: I would have to review the charts, I'm sorry.

MR. FALK: I'm sorry, I was going to interpose an objection that she can testify from her personal experience, but she's already said that -- but she answered. So I apologize.

Q So you don't recall any specific patients that fit that category that --

DR. CATHERINE BAST: No, I don't recall.

Q Okay. Are there risks involved if you give a child before Tanner stage 2 puberty blockers?

DR. CATHERINE BAST: I don't know the answer to that question.

Q So a child in that position before Tanner stage 2

Page 77

presents with gender dysphoria. What treatment do you provide?

DR. CATHERINE BAST: Well, I provide a welcoming space. I call them by the name they choose. I call them by the pronouns that they choose. And I engage in dialogue with the parents and the family about how they interact in the world.

Q Anything else?

DR. CATHERINE BAST: If we're only talking about gender dysphoria, yes. Remember that I'm a family practice doctor, so ...

Q I am only talking about gender dysphoria when they're too young for puberty blockers. That's it, nothing else?

DR. CATHERINE BAST: That's correct.

Q So then when the minor is old enough for puberty blockers, what are some of the risks of taking puberty blockers?

DR. CATHERINE BAST: To the best of our knowledge, there are no long-term sequelae from the puberty blockers. There are some rare instances of people experiencing some side effects related to hormonal dysfunction. For example, people who go on puberty blockers who have a uterus sometimes

Page 78

have one episode of vaginal bleeding, so that can be a side effect. People who go on puberty blockers might see an increase in nocturnal emissions. That could be a possible side effect. But those are the ones that are the most common.

Q I take it when you're talking about the vaginal bleeding, you're not talking about with reference to menstruation, something else?

DR. CATHERINE BAST: If the person in Tanner stage -- that we -- yes, yes, I'm talking about vaginal bleeding that's menstrual related.

Q Oh, that's menstrual?

DR. CATHERINE BAST: Yes.

Q And that's a side effect of taking testosterone?

DR. CATHERINE BAST: No, that can be a potential side effect of taking puberty blockers.

Q I'm sorry, of taking puberty blockers, right. So I'm just a little surprised only because I would have thought, you know, menstruation is what you expect at puberty and so maybe the blocker hasn't had full effect, but that's not really a side effect, is it?

DR. CATHERINE BAST: So in my experience, I have not had any patients with these side effects. What I am telling you is what I read about the use

Page 79

of these medicines and the potential side effects that I talk about.

Q Okay, very good. Let's go back to Exhibit 10. This is the informed consent for balancing hormones document. Yes, there we go.

So under what we know, it says, "We know that long-term blocking of testosterone and estrogen will weaken bones."

You see that?

DR. CATHERINE BAST: Uh-huh.

Q Tell me what you know about that statement.

DR. CATHERINE BAST: Based on the use of puberty blockers in children with central precocious puberty, there does seem to be a length of time after which bone development is affected along with the time of being on the medicine. We don't know exactly what that length of time is, but we suspect it is about three years.

Q Is that -- so this is on this disclosure statement, and I guess I'm wondering, do you structure the treatments with your gender dysphoric minor patients so that they're done with puberty blockers within three years or do you -- is that sort of immaterial to how you structure their treatment?

DR. CATHERINE BAST: It's case -- it's

Page 80

individual patient based.

Q So you warn them that maybe there's -- maybe there's this three-year kind of mark that they need to be aware of when deciding whether to then proceed to hormones?

DR. CATHERINE BAST: I warn them that there is some evidence that being on puberty blockers for three years or longer may weaken bones.

Q Do you have a sense of how many of your patients that are on blockers who are gender dysphoric move on to hormones within the three years of using the blockers?

DR. CATHERINE BAST: I don't know time. No, I couldn't give you a sense of that, no.

Q Is it your practice to have some sort of follow-up conversation at about the three-year mark of using puberty blockers to remind the patient of this risk?

DR. CATHERINE BAST: Yes.

Q Do you have patients that, not withstanding that follow-up conversation and reinforcement of that risk, choose to continue with puberty blockers?

DR. CATHERINE BAST: I couldn't tell you without reviewing all the charts.

MR. FALK: Hey, Tom, it's been about another

Page 81

hour or so. I didn't know what your plans were and how much longer you have and whatnot.

MR. FISHER: Yeah. Well, we'll -- we will certainly be coming back after lunch. I think --

MR. FALK: You want to go for another hour, take a break and then have lunch or --

MR. FISHER: Yeah, I'm thinking probably something like that. Maybe not quite a full hour. But I would like to go a little farther unless somebody needs it -- if anybody needs a bathroom break, that's fine. But I'd like to otherwise press on.

MR. FALK: Okay. We're fine here then.

MR. FISHER: Okay.

BY MR. FISHER:

Q Doctor, in the context of Exhibit 11, which I understand is not a document you currently use --

MR. FISHER: Oh, is that 11? I'm sorry. There we go.

Q Within 11, and even though you don't continually use it, there was a term that came up, buying time. Where is that? Can you see that in there?

MR. FALK: Can you point it out if you know where it is, Tom?

MR. FISHER: I'm looking for it. I have it in

Page 82

my notes.

MR. FALK: Oh, yeah, second -- third sentence.

MR. FISHER: Third sentence, okay. Yeah, there it is, in order to buy time.

Q Doctor, what do we mean -- what do you mean by that?

DR. CATHERINE BAST: I mean that it gives the -- it gives relief to the patient to not have to go through the puberty that isn't associated with their -- with their gender identity.

Q Well, okay. I guess I'm wondering about the nature of the gender dysphoria again and does gender dysphoria in your prepubertal patients -- and maybe those who are sort of approaching but not quite yet at Tanner stage 2 or maybe right at Tanner stage 2, I'm still uncertain exactly how much window we have to work with there, but that they're eligible for puberty blockers. Do they all have the same, I guess manifestation of gender dysphoria as it relates to puberty? Do they all fear puberty in the same way?

DR. CATHERINE BAST: In my experience, yes.

Q Is there any other way that they -- that their gender dysphoria has some kind of concrete manifestation?

Page 83

DR. CATHERINE BAST: I'm sorry, I don't understand the question.

Q I know. It's really -- I'm having a hard time articulating it. They're afraid of puberty, but is there something else about their gender identity as it relates to their natal sex that gives them distress?

DR. CATHERINE BAST: Well, in my experience, patients who come to me in this situation, so pre-Tanner stage 2, they are already living in a social capacity and with their name and their pronouns as the gender that they identify with. Otherwise, there would be significant distress. Or they describe to me significant distress before they started to live that way.

Q Would a physician -- would a physician ever need to prescribe cross-sex hormones to a non-transgender minor?

DR. CATHERINE BAST: Could you describe what you mean by "cross-sex hormones"?

Q Yeah, would a physician ever need to prescribe estrogen to a natal male that wasn't transgender?

MR. FALK: And again, I'm going to object. That's asking for an expert opinion. She can certainly testify as to whether she has ever -- or

Page 84

under circumstances where she would ever, if that's the case. But I don't think she can opine as to what other doctors might, given her -- that she's not being qualified as an expert.

DR. CATHERINE BAST: I have never -- I don't -- in my experience, I have not -- I have not prescribed estrogen to someone assigned male at birth for any other reason.

Q And what about testosterone for someone -- a natal female who is not transgender?

DR. CATHERINE BAST: I have not prescribed testosterone for anyone assigned female at birth as a -- yeah, for any other reason. A youth for any other reason than gender dysphoria.

Q With testosterone for natal females, what unwanted side effects might occur?

DR. CATHERINE BAST: I don't know what you mean by "unwanted."

Q Well, I'm trying to distinguish between the outcomes that they want, and which I assume are secondary sex characteristics, and any outcomes that may likely occur but that they don't want, I'm just wondering if there's anything that comes up with using testosterone on natal females that is unwanted as a result.

Page 85

DR. CATHERINE BAST: The only potential side effect that we watch for is this rising of the hemoglobin level that I talked about before.

Q And what do you do to treat that if that happens?

DR. CATHERINE BAST: Moderate the dose.

Q What is the risk of having too much hemoglobin?

DR. CATHERINE BAST: There would be a point at which a hemoglobin level would be too high that would make a blood more coagulable. And so we need to keep it within the range of normal.

Q Okay. So switching over, then, to estrogen for natal males. Any side effects that need to be treated sometimes?

DR. CATHERINE BAST: We're looking -- I have had a few natal females with a co-existing coagulation disorder develop a blood clot on estrogen. Those are adults.

Q Okay. You said natal female, and I was wondering about natal males on estrogen.

DR. CATHERINE BAST: So folks who were assigned male at birth who are on estrogen, that's who I was talking about. I've had -- yeah.

Q Okay. So do you tell your minor natal male patients who may go on estrogen, who are seeking to go on estrogen, that if they later decide to stop

Page 86

and to -- I don't know, just to stop the estrogen, that they may, notwithstanding that, not produce mature sperm?

DR. CATHERINE BAST: I tell them that's possible, yes.

Q What is the likelihood that estrogen treatments may cause permanent sterility in a natal male?

DR. CATHERINE BAST: I don't know what the data says on that.

Q So going back to the document, I know it's not one that you use in practice, but the one that says Testosterone for Transgender Clients -- I sort of lost track of which one this is.

MR. FISHER: Oh, it's 13.

MR. FALK: 13.

Q 13. Oh, I'm sorry, I had the wrong document. So back to Dr. Bast's declaration.

MR. LANE: It should be Exhibit 7.

MR. FISHER: Great, thank you.

Q In paragraph 27 on page 6 of that declaration. So the last sentence, the first clause says, "There are no protocols that define how to stop gender-affirming hormones."

So, I mean, you had one patient, right, that wanted to do that; is that right?

Page 87

DR. CATHERINE BAST: Correct.

Q And what was the protocol? What did you do?

DR. CATHERINE BAST: They did it on their own. They didn't follow a protocol. They didn't -- yeah.

Q Did that person continue to see you during that process?

DR. CATHERINE BAST: They saw me after they had stopped, yes.

Q Oh, do you know how long after they stopped?

DR. CATHERINE BAST: No, I'm sorry. I'd have to review the chart.

Q Okay. And do you tell your patients that are going to go on hormones that there are no protocols defining how to stop if they eventually wish to stop?

DR. CATHERINE BAST: I have not said that specifically, no.

Q So estrogen treatments for natal males, I want to ask you about some specific risks, just -- again, I'm just wondering if you know about these risks. Any risk of stroke?

DR. CATHERINE BAST: It is a theoretical risk of stroke, yes.

Q Risk of elevated blood pressure?

Page 88

DR. CATHERINE BAST: There is a theoretical risk of that, yes.

Q Risk of gallstones or gallbladder surgery?

DR. CATHERINE BAST: There is the theoretical risk of that, yes.

Q The risk of effects on bone development?

DR. CATHERINE BAST: Theoretically, yes.

Q And we've talked already the risk of lower sperm count later in life. Do you tell your patients about all those risks?

DR. CATHERINE BAST: Yes. They're part of our conversation.

Q Okay. Talk about -- let's talk about testosterone for natal females. What about risks to bone development; are there risks?

DR. CATHERINE BAST: Theoretically, yes.

Q Risks for high blood pressure?

DR. CATHERINE BAST: Theoretically, yes.

Q Risks to the development of eggs later in life?

DR. CATHERINE BAST: Theoretically, yes.

Q Risks of psychological behaviors or conditions related to the testosterone?

DR. CATHERINE BAST: Theoretically, yes.

Q Do you advise your natal female patients seeking to go on testosterone of all those risks?

Page 89

DR. CATHERINE BAST: They're all part of our discussion, yes.
Q Are there any other physiological risks for either of those treatments, either testosterone for natal females or estrogen for natal males, that we haven't talked about?
DR. CATHERINE BAST: No, I don't believe so.
Q Are there any other psychological risks for either of those treatments that we haven't talked about?
DR. CATHERINE BAST: No, I don't believe so.
Q So when you've got a transgender minor that's gone through -- maybe they've been through puberty blockers and they -- I don't know, I guess I'm wondering, at some point you're having conversations, I assume, about cross-sex hormones. Maybe you don't have a -- you know, maybe the timeline is all over the place on very individual dependent, but do you ever encounter a minor who says, you know, I just don't want cross-sex hormones?
DR. CATHERINE BAST: Not in my experience.
Q Are there any situations for gender dysphoric minors where puberty blockers or cross-sex hormones would always be inappropriate.
DR. CATHERINE BAST: There are medical

Page 90

contraindications to estrogen and testosterone. So estrogen in medically contraindicated in somebody who has a known estrogen sensitive cancer. And testosterone is medically contraindicated in pregnancy and in somebody who has a known testosterone sensitive cancer.
Q In those circumstances, what treatment for gender dysphoria is available?
DR. CATHERINE BAST: In that circumstance, it would be similar to the treatment available to all transgender people that we call them by the -- we create a welcoming space and we call them by the name that they choose. We use the hormones that they choose.
Q Well, but I think did you say hormones? Because I thought that's what we were talking about.
DR. CATHERINE BAST: Pronouns. Sorry, pronouns that they choose.
Q Do you offer any sort of mental health treatment?
DR. CATHERINE BAST: In the context of a family practice office, that's always available, yes.
Q Have you actually -- and maybe you -- I don't know, were you speaking theoretically or have you had patients who have had those contraindications?

Page 91

DR. CATHERINE BAST: I have not.
MR. FALK: How are we doing for a break, Tom?
MR. FISHER: Yeah, just a little bit more and then we can break, if you can bear with me.
Q All right. Paragraph 26 of your declaration, the penultimate sentence says, "The inability to obtain this treatment" -- and in here I think we're talking both blockers and hormones -- "the inability to obtain this treatment will cause anxiety, depression, stress, and suicidality." You see that?
DR. CATHERINE BAST: Yes.
Q And I'm wondering, what is the basis for that belief?
DR. CATHERINE BAST: It's my experience, both of my encounters with youth prior to treatment and also my conversations with youth currently about the possibility of treatment being outlawed.
Q Have you had -- have you experienced patients who have been on blockers and stopped and experienced this symptoms?
DR. CATHERINE BAST: No.
Q Have you had patients or minors who were on hormones and stopped because they experience these symptoms?

Page 92

DR. CATHERINE BAST: No.
Q The term "gender-affirming surgery," does that term mean something to you?
DR. CATHERINE BAST: You're asking me to define it.
Q Yeah, it's a term that I'm just wondering if you have a -- yeah, what does it mean? There you go.
DR. CATHERINE BAST: Gender-affirming surgery, as I understand it, is surgical interventions to change the body so that it matches the gender of the identity of the patient.
Q Well, specifically we already talked about I think what you described as top surgery. So that's one, I suppose; is that right?
DR. CATHERINE BAST: Yes, chest reconstruction surgery. Yes, top surgery, uh-huh.
Q Okay. What are other examples of gender-affirming surgery?
DR. CATHERINE BAST: Metoidioplasty, vaginoplasty, phalloplasty, tracheal shave, breast augmentation, facial feminization surgery.
Q Anything else?
DR. CATHERINE BAST: Those are the only ones I can think of off the top of my head.
Q Okay. Is gender-affirming surgery ever appropriate

Page 93

for minors?
MR. FALK: Again, it's asking as an expert. She can answer as to her own personal experience or what she knows as a doctor, but I don't think she can give an expert opinion as to what is appropriate and what is not appropriate.
Having said that, you can answer.
DR. CATHERINE BAST: In my experience, I don't have any youths who have had gender-affirming surgery in Indiana.
Q Okay. Well, I guess I'm wondering if youths stressed a desire to have gender-affirming surgery before the 18th --
DR. CATHERINE BAST: I have had --
MR. FALK: Let him finish.
DR. CATHERINE BAST: Okay, sorry.
MR. FALK: You're good.
DR. CATHERINE BAST: Before the age of 18, yes, I have had patients who have expressed a desire to have gender-affirming surgery when they are at a time when they are not yet 18 years old.
Q And have you found that that treatment would be appropriate for those patients?
DR. CATHERINE BAST: It hasn't been available, so I haven't had that experience.

Page 94

Q What do you mean, it hasn't been available?
DR. CATHERINE BAST: My patients have -- under the age of 18 have not been able to have any surgical interventions.
Q Why?
DR. CATHERINE BAST: Well, in Indiana there isn't anybody doing gender-affirming surgery for anybody under the age of 18.
Q Including at Mosaic?
DR. CATHERINE BAST: Correct. We do not do surgery.
Q Do you have any plan to start doing gender-affirming surgery in the future?
DR. CATHERINE BAST: No.
Q Do you make referrals for surgical interventions, for this -- for gender-affirming surgery?
DR. CATHERINE BAST: Yes.
Q And have you made referrals for minors seeking gender-affirming surgery?
DR. CATHERINE BAST: No.
Q Why not?
DR. CATHERINE BAST: Because it's not available.
Q Well, I mean, you could refer it to somebody out of state, couldn't you?

Page 95

DR. CATHERINE BAST: I haven't ever done that.
Q Why not?
DR. CATHERINE BAST: In my experience, it hasn't come up.
Q You haven't ever said, well, nobody in Indiana does gender-affirming surgery on minors, but I can refer you to somebody, I don't know, in Michigan or Illinois or Ohio?
DR. CATHERINE BAST: No. It hasn't come up.
Q I guess I'm wondering, when it comes to referrals, are you the one that brings it up or are the patients the ones that bring it up?
DR. CATHERINE BAST: I follow a patient's lead.
Q Is that true in all situations or only with respect to gender dysphoria and surgery?
DR. CATHERINE BAST: Especially in regards to gender dysphoria and surgery, I am not -- I follow the patient's lead.
Q Why is that?
DR. CATHERINE BAST: Because it's their body.
Q Well, but you said especially. It's always their body. But you said "especially" in this context. And I'm wondering why "especially" in this context.
DR. CATHERINE BAST: I misspoke. I don't

Page 96

think there's any situation in which I would not follow a patient's lead on their desire for surgery.
Q Well, what about any other treatment that you don't offer at Mosaic that the patient is interested in, do you ever initiate a conversation about referral?
DR. CATHERINE BAST: I can't recall that I do.
Q But if a patient brings it up, you have some ability or you have some places that you're aware of where you can refer patients, in general?
DR. CATHERINE BAST: If somebody brings it up, then we'll talk about what I know and the possibilities of referral, if there are possibilities.
MR. FALK: And I'm just going to interpose an objection as to I've lost track of what "it" is because we started off talking about general surgery, and then I don't know that we're talking specifically about with transgender issues, so ...
MR. FISHER: That's fine, Ken, I'll refocus here.
Q With respect to gender-affirming surgery on minors, if a patient brings up and wants a referral, do you have places to refer?
DR. CATHERINE BAST: I could find them. I

Page 97

haven't ever done it.
Q Oh, okay. So you've never had to vet any possible places to refer patients for that?
DR. CATHERINE BAST: Not for youth.
Q And what about for adults?
DR. CATHERINE BAST: I do have -- I have provided referrals for adults wanting gender-affirming surgery.
Q Referrals out of state?
DR. CATHERINE BAST: If they desire, yes.
Q Would you refer youth to the same places?
DR. CATHERINE BAST: It's a completely different surgical practice, so no, not necessarily.
Q Why is it a completely different surgical practice?
DR. CATHERINE BAST: Well, generally -- in general, in my experience, surgeons who operate on adults are not necessarily the same ones who are going to operate on youth.
Q With respect to gender-affirming surgery?
DR. CATHERINE BAST: Well, with respect to surgery in general.
Q Surgery in general. Do you know that to be the case with respect to gender-affirming surgery or you're just assuming it's like other surgeries?

Page 98

DR. CATHERINE BAST: I don't know for certain.
MR. FISHER: Okay. I think that's a good place to take a break for lunch.
DR. CATHERINE BAST: Thank you.
(Lunch recess taken.)
BY MR. FISHER:
Q So let's go back to Exhibit 10, if we can, please. This is the informed consent document.
Doctor, now my understanding is this is the informed consent document you use for puberty blockers; is that right?
DR. CATHERINE BAST: Yes.
Q Do you use a different document for informed consent when it comes to hormones?
DR. CATHERINE BAST: Yes.
Q I guess I don't think we have that since what Gavin -- not just Gavin, but others, since what your lawyers sent are documents that you don't use. I guess I don't think we have --
MR. FALK: Can we go off the record for a second, Tom?
MR. FISHER: Yeah.
(Discussion held off the record.)
BY MR. FISHER:
Q Doctor, I want to talk a little bit about some of

Page 99

the -- I guess some of the disclosures and pretreatment assessments, you know, we'll hopefully get the informed consent docs in due course here and we can bring those in. But at the moment, we'll just go based on your memory or your understanding.
When a minor comes in and presents with gender dysphoria, do you -- is part of your informed consent process to give the minor and the parents literature about gender dysphoria and possible treatments, or is it merely an oral conversation where you make your disclosures?
DR. CATHERINE BAST: The literature that we give is what we provided you.
Q Oh, okay. So like the guide for the parents and that sort of thing?
DR. CATHERINE BAST: Uh-huh.
Q Okay. What information do you provide -- and this is one where I'm not entirely sure who -- whether this is going to be Mixhi or Dr. Bast, but I'm wondering about information about -- concerning Medicaid reimbursements for puberty blockers and hormones.
MIXHI MARQUIS: There's no -- there's no information that we give. If someone's covered by

Page 100

Medicaid, we -- it's simply our normal process, yeah, of consent to bill, to bill Medicaid.
Q What about insurance?
MIXHI MARQUIS: Insurance as well.
Q Same. Same thing, yeah.
Do you -- Doctor, do you think of puberty blockers to be experimental?
DR. CATHERINE BAST: No.
Q Do you think of hormones for gender dysphoria to be experimental?
DR. CATHERINE BAST: We have used estrogen and testosterone treatment for years. No.
Q You've used them -- okay, but I'm talking, just to be clear, specifically in the context of gender dysphoria.
DR. CATHERINE BAST: No, this treatment has been -- is standard medical practice for the diagnosis of gender dysphoria.
Q Is that true with respect to minors? Is it experimental with respect to minors?
DR. CATHERINE BAST: It's still the standard of care with minors.
Q Do insurance companies pay the claims for puberty blockers and hormones for gender dysphoria?
DR. CATHERINE BAST: To the best of my

Page 101

knowledge, yes.
Q If the insurance companies thought of those treatments as experimental, would they pay those claims?
MR. FALK: I guess I'll just interpose an objection just because I don't know how the witness can testify as to what insurance companies do. But maybe she knows. I don't know what insurance companies do.
DR. CATHERINE BAST: Yeah, I don't know.
Q Mixhi, do you know?
MIXHI MARQUIS: No, I do not know.
Q Have you ever had any sort of insurance claim denied on the grounds that it was an experimental treatment?
MR. FALK: And Tom, are you asking for anything?
MR. FISHER: For anything, yeah.
DR. CATHERINE BAST: Not to my knowledge, no.
MIXHI MARQUIS: Not to my knowledge.
Q You know, I think at this point we can just go into the M.R. medical records.
MR. FISHER: So I'm sorry, is this 12? 13? 14? 14.
(Deposition Exhibit 14 marked.)

Page 102

Q Doctor, do you have the full document, the full medical record document in front of you?
DR. CATHERINE BAST: I do.
Q Okay. And I take it, at least as to the cover sheet, it matches what's up on the screen?
DR. CATHERINE BAST: Yes.
Q Okay. Can you identify this document, please.
DR. CATHERINE BAST: Yeah, this is the medical record for patient --
Q Just use initials. Initials, please.
DR. CATHERINE BAST: -- M.R., date of birth 9-18-2007.
Q As you leaf through it, does it look like the complete and accurate medical record?
DR. CATHERINE BAST: Yes, it does.
Q All right. When did M.R. first come to Mosaic?
DR. CATHERINE BAST: Early May 2023. No, that was the date it was printed. Sorry. First appointment -- I'm trying to see if this is in -- it's in reverse chronological order. First appointment was February 17, 2023.
Q So who saw M.R. on that first appointment?
DR. CATHERINE BAST: I did.
Q Did anybody see M.R. before you did at Mosaic?
DR. CATHERINE BAST: No.

Page 103

Q So were you the first person to observe gender dysphoria symptoms in M.R.?
DR. CATHERINE BAST: Are you asking at Mosaic or --
Q I'm sorry, at Mosaic, yes.
DR. CATHERINE BAST: At Mosaic, yes.
Q Yes, okay. What were those symptoms that you observed?
DR. CATHERINE BAST: Well, I want to clarify that they came to me with a diagnosis of gender dysphoria.
Q Oh, okay. Thank you. Where was that diagnosis made?
DR. CATHERINE BAST: That was made at Michiana Behavioral Health on their inpatient stay.
Q And when was that made?
DR. CATHERINE BAST: Discharge from that facility was, it looks like, February 3rd. So I don't know if that was the same day as the diagnosis, but that was the discharge.
Q And then, I'm sorry, what day did M.R. present at Mosaic?
DR. CATHERINE BAST: February 17th.
Q So two weeks between the two?
DR. CATHERINE BAST: Approximately, yes.

Page 104

Q Yeah, okay. But still, did you observe symptoms of gender dysphoria with M.R.?
DR. CATHERINE BAST: I did.
Q What were those symptoms that you observed?
DR. CATHERINE BAST: They came to me indicating that they had been -- they had felt for most of their childhood life that they were a boy and that since puberty, and especially since this year in school, were experiencing significant distress based on not being treated and not being identified by other people as a boy.
They reported to me that they had had suicidal ideation related to this and that they were inpatient at Michiana Behavioral Health because the suicidality was significant enough that it was felt that they weren't safe -- that they needed hospitalization in order to get them started on treatment and keep them safe.
And so part of their discharge planning from this inpatient psychiatric facility was to seek care at Mosaic for -- to seek treatment for their gender dysphoria. And they reported to me significant depression and previous history of self-harm related to their distress over not having a body that reflected their gender identity.

Page 105

Q Any -- so you mentioned -- did you say severe depression or significant? I can't remember which word you used.

DR. CATHERINE BAST: I don't remember which word I used either.

Q Are they different or are they the same, roughly?

DR. CATHERINE BAST: At the Michiana Behavioral Health, I believe they were diagnosed with major depressive disorder. I'm just confirming that.

Q Okay. Any other psychological symptoms that M.R. presented with other than major depressive disorder?

DR. CATHERINE BAST: They came to me also having had a previous diagnosis from another pediatric office of attention deficit hyperactivity disorder. But we didn't address that at their first visit.

Q Could you observe any symptoms connected to ADHD?

DR. CATHERINE BAST: Not at that first visit, no.

Q Did you later?

DR. CATHERINE BAST: Later I did, yes. Subsequent visits I did.

Q What symptoms of ADHD did you observe later?

Page 106

DR. CATHERINE BAST: Inability to pay attention to questions and difficulty in focusing on the task at hand. A reported loss of keys and phone and ID on multiple occasions. Those are the ones that I remember.

Q So M.R. had presented with a prior diagnosis of gender dysphoria; correct?

DR. CATHERINE BAST: Yes.

Q And then in your, I guess your role, what did you think your role was at that point when M.R. presented? What were you -- what did you need to do?

DR. CATHERINE BAST: Well, as I understood it, I was being -- I was being asked to follow up for two reasons, to be their primary care provider, which they were without one for a while; and also to consult and provide treatment for gender dysphoria.

Q Did you see it as your role to make your own independent assessment of gender dysphoria?

DR. CATHERINE BAST: As I would do with any patient coming to my office, I would do a review of their materials from other doctors that we had collected. And yes, I do feel like it is my role to confirm and support the diagnoses given by other

Page 107

people after review of the documents and the notes provided.

Q Well, what if you couldn't confirm it?

DR. CATHERINE BAST: I'm sorry, I'm not sure what you're asking.

Q Well, there was a prior diagnosis. The patient presents. You think it's your job to confirm, which I guess I'm -- maybe I'm not quite sure what you mean by "confirm." Do you think that you have a role in second-guessing that earlier diagnosis?

MR. FALK: And again, Tom, just you're asking kind of the hypothetical patient, not in this case where --

MR. FISHER: That's right.

Q Well, yeah, I mean, I think it is this case, but it's every case where somebody comes in with a diagnosis, and particularly a diagnosis of gender dysphoria. Do you have a role to play in second-guessing that earlier diagnosis.

DR. CATHERINE BAST: I wouldn't call it second-guessing, but I have -- I do have a responsibility in the ethical care of my patient to collect as much information as available to me and use all that information in making a determination of the right care plan for this patient.

Page 108

Q Even if that right care plan is that this person does not have gender dysphoria?

DR. CATHERINE BAST: I'm treating each patient in front of me with the information that I'm given and with what they -- and with what they tell me, yes.

Q Do you acknowledge that it's possible that somebody with a previous diagnosis of gender dysphoria could present to you and you might disagree with that diagnosis?

DR. CATHERINE BAST: It's hypothetically possible, yes.

Q So when you saw M.R. and M.R. conveyed the story that -- about -- I don't mean -- I don't mean that pejoratively, I just mean the back -- you know, the backstory, you were taking that and processing it and coming to your own conclusion about gender dysphoria?

DR. CATHERINE BAST: Yes. I take all the data that I have into consideration. The data from M.R. Also from the parents, uh-huh.

Q Well, what did you learn from the parents about M.R. and gender dysphoria here?

DR. CATHERINE BAST: Well, they indicated that M.R. had expressed for many years that their gender

Page 109

identity was not congruent with their sex assigned at birth and that they had witnessed puberty increasing distress and suicidal ideation and self-harming behavior in M.R.

Q So did you come to a conclusion about -- I guess the time -- length of time with which M.R. had been dealing with gender dysphoria?

DR. CATHERINE BAST: In conversation with M.R. and the parents, it was clear that this was ongoing for a number of years.

Q Okay. Is that -- anything more precise than that or just "a number of years"?

DR. CATHERINE BAST: That was what I heard. That was -- uh-huh.

Q Did they give you anything more specific about their first observations of M.R.'s gender dysphoria, how that manifested itself?

DR. CATHERINE BAST: No, they didn't at that point. They were more focused on the worsening of it by puberty.

Q So do you know who at the hospital made the diagnosis of M.R. as gender dysphoric?

DR. CATHERINE BAST: I can only tell you who signed the psychiatric evaluation.

Q Who was that?

Page 110

DR. CATHERINE BAST: Teresa Benefit, APN.

Q Do you know that person?

DR. CATHERINE BAST: No, I do not.

Q So you don't know whether that person has training in child and adolescent developmental psychology?

DR. CATHERINE BAST: I do not know their training, no. I do know they work at a child and adolescent inpatient psychiatric facility.

Q And I guess, I don't know, it's been long enough since we've talked about your education and training, I want to go back to this, but do you have training in child an adolescent developmental psychology and psychopathology?

DR. CATHERINE BAST: Within the scope of family medicine, yes.

Q What do you mean, "within the scope of family medicine"?

DR. CATHERINE BAST: What I mean is that as a family physician, I am educated in and qualified to treat all myriad of disorders, many disorders and many health concerns from childhood through adulthood. And a basic understanding of psychopathology is included in that training. And we are also trained to do psychiatric triage and prescribe medicines to treat psychiatric disorders.

Page 111

Q All right. So let's turn to page 3. It says page 3 of 34 in this Exhibit 14.

So can you tell me what this page is doing?

DR. CATHERINE BAST: Page 3 of 34?

Q Yes.

DR. CATHERINE BAST: This is what we call the face sheet, so it has basic demographics on the patient, a problem list, a medications list, and then it moves into some history, history questions.

Q Is it important for the information on this page to be accurate?

DR. CATHERINE BAST: We strive for accuracy, yes.

Q So under "Problems," do you see it says, "Gender dysphoria - onset 2-15-23"?

DR. CATHERINE BAST: That date is the first time it was mentioned in our medical record.

Q But is there anywhere in this record that it shows the, I guess, more accurate onset date that number of years record?

DR. CATHERINE BAST: I guess the place that it's diagnosed or that it's listed is in the psychiatric evaluation from Michiana Behavioral Health.

Q Which page is that?

Page 112

DR. CATHERINE BAST: Which is 31 of 34 -- sorry. 30, 30 of 34.

Q 30 of 34.

DR. CATHERINE BAST: That's the earliest date that we have.

Q Is that at the bottom?

DR. CATHERINE BAST: Under "Admitting Diagnoses," yes.

Q And this date is 2-3-23?

DR. CATHERINE BAST: That's the first record we have available, yes.

Q So back on page 3, it says "Medications." Some of this I recognize. Some I don't. Can you just go through each of these and tell me what they're telling us?

DR. CATHERINE BAST: Yes. So the syringes, the 3 milliliter by 22 gauge and one half, those are for injection of testosterone. The syringe with 3 milliliter and 18 gauge and 1 and a half needles, those are to draw up the testosterone from the vial. Fluoxetine is a medication that's used to treat depression. Guanfacine is a medication that's used to treat ADHD. And then testosterone.

Q No record of vaccines; is that what it says?

DR. CATHERINE BAST: That's correct. There

Page 113

must not have been -- they must not have been in the CHIRP system, which is what auto populates into our system when somebody new, a new child is here.

Q Is it important to know about vaccines before prescribing medications?

DR. CATHERINE BAST: It's not something that I routinely ask about before prescribing medications, no.

Q Well, do you routinely consult whatever the auto populated record is to see?

DR. CATHERINE BAST: Yes. If it's auto populated and I'm reviewing it before seeing the patient, then yes, I review them.

Q But if there's nothing there, you don't ask the question?

DR. CATHERINE BAST: If there's nothing there, then I ask where we can get them.

Q Did you ask in this case?

DR. CATHERINE BAST: I don't recall.

Q So then "Past medical history," things we've talked about: ADD/ADHD, depression, those both have Ys; headaches has a Y; hospitalization has a Y. The only thing we haven't talked about here is the headaches.

DR. CATHERINE BAST: Uh-huh.

Page 114

Q Did you do an assessment of the -- what was happening with the headaches?

DR. CATHERINE BAST: Not in my first appointment, no.

Q Did you not think that that was important for figuring out a course of treatment?

DR. CATHERINE BAST: Not in the treatment of gender dysphoria, no. And that was the presenting issue.

Q So that was the only thing you were concerned about?

DR. CATHERINE BAST: There was nothing in the assessment or treatment of headaches that would change any treatment for gender dysphoria. So in that sense, I was addressing the presenting issue of the patient in the first appointment.

Q The only reason for you to be concerned with the headaches was if it had something to do with gender dysphoria; is that another way of saying it?

DR. CATHERINE BAST: No. In that appointment, their stated desire and reason for visit was gender dysphoria. I wanted to address that first and foremost. And I took into consideration the fact that any treatment that we may or may not down the line do for headaches did not change how we might treat gender dysphoria.

Page 115

Q So did you ask about the headaches that first visit?

DR. CATHERINE BAST: I don't recall.

Q Let's turn over to page 4. Under "Social History, Substance Use," the third line down, it says, "What is your level of alcohol consumption?: Moderate." "How many years have you consumed alcohol?: 1." You see that?

DR. CATHERINE BAST: Uh-huh.

Q Did you notice that information before making a prescription for hormones for M.R.?

DR. CATHERINE BAST: Yes. It was part of the psychological evaluation too.

Q Did that -- and M.R. would have been -- M.R. is, I guess, I want to say 15 years old; is that your understanding?

DR. CATHERINE BAST: Yes.

Q So under the legal drinking age, it's fair to say; is that right?

DR. CATHERINE BAST: Correct, uh-huh.

Q Did M.R.'s use of alcohol give you any concern about prescribing a course of treatment?

DR. CATHERINE BAST: To the best of my understanding from the behavioral health evaluation and also my experience of talking to M.R. in the room, the use of alcohol was directly related to the level of depression and distress and dysphoria that they were experiencing.

Page 116

Q Okay. So what -- let's talk about that initial evaluation. Who did this -- you said it was a psychosocial evaluation; is that accurate?

DR. CATHERINE BAST: Yes. It was a psychiatric evaluation done at Michiana Behavioral Health.

Q Oh, that's what you're -- okay. That's the one you're talking about?

DR. CATHERINE BAST: Yeah.

Q Okay. So did you think it was important to address the alcohol consumption aside from gender dysphoria?

DR. CATHERINE BAST: In my experience with adolescents and gender dysphoria, once the gender dysphoria is treated, many things, many other behaviors diminish. Self-harm behaviors, including substance use.

So my -- while this is an important piece of information in terms of M.R.'s life and context and history, my experience was to focus on their stated need, to treat the gender dysphoria, and then to

Page 117

continue to monitor the alcohol use after that.
Q Okay. You didn't think that it would be appropriate to wait until M.R. quit using alcohol before proceeding with hormone treatment?
DR. CATHERINE BAST: That wasn't a criteria that I presented to M.R., no.
Q Okay. Is there anything in the -- in this medical record that shows whether M.R. has -- and I know it hasn't been that long, but has M.R. ceased using alcohol?
DR. CATHERINE BAST: I don't know the answer to that question. We do have documented of improved mood, however, and reduction in depressive symptoms and a reduction in cutting behavior and suicidality. But nothing particular with alcohol, no.
Q Do you think that those behavioral changes are due to the testosterone?
DR. CATHERINE BAST: I believe that the behavioral changes are due to M.R. having more congruence between his identity and his body.
MR. FALK: Off the record for a second.
(Discussion held off the record.)
BY MR. FISHER:
Q Doctor, are you aware that testosterone given to

Page 118

women who suffer depression has been shown to alleviate depression even when they don't have gender dysphoria?
DR. CATHERINE BAST: I am not aware of those studies, no.
Q So under "Lifestyle," are you with me there? It says, "Are you or have you been involved with bullying?: Yes."
Do you know anything more about -- about that with M.R.?
DR. CATHERINE BAST: M.R. was the recipient of taunts and name-calling.
Q Nothing -- no accounting where M.R. was acting out and bullying others?
DR. CATHERINE BAST: Nothing that I have or know of.
Q And then under the next one, "Do you feel stressed (tense, restless, nervous, anxious, unable to sleep at night)?" It says, "Rather much."
Did you assess M.R. to figure out what the sources of those stress symptoms could be?
DR. CATHERINE BAST: Yes. And we talked about the bullying, and we talked about the gender dysphoria, and they said that those were the primary sources of their stress.

Page 119

Q Is it possible that anxiety can have more than one source or could have been from a different source?
DR. CATHERINE BAST: Are we talking about anxiety or the stress?
Q Well, anxiety -- it says "anxious" under -- as a subcategory of stress. So I was equating that with anxiety. Is that a different thing?
DR. CATHERINE BAST: Well, M.R. doesn't carry currently a diagnosis of anxiety, only of depression.
Q Okay. So anxious stress is different from anxiety?
DR. CATHERINE BAST: I would have interpreted that in this case, yes.
Q Okay. Under "Screening" at the bottom, do you see that?
DR. CATHERINE BAST: Yes.
Q What is that telling us?
DR. CATHERINE BAST: That's telling us the screenings that are available. But if those screenings were done, there would be a score.
Q Well, what is each screening?
DR. CATHERINE BAST: GAD-7 is a screening for anxiety. PHQ-2/PHQ-9 is a screening for anxiety. And the Vanderbilt Parent and the Vanderbilt Teacher are both screenings available for ADHD.

Page 120

They auto populate in the chart when there is a diagnosis of either depression or ADHD. All four of those auto populate in the chart. Not necessarily -- as being available as tools.
Q But none was undertaken at Mosaic for M.R.; right?
DR. CATHERINE BAST: Not in that encounter.
Q What about at a different encounter?
DR. CATHERINE BAST: Well, that's what I'm looking.
Q Okay.
DR. CATHERINE BAST: It looks like on the bottom of page 10, GAD-7 was not scored on that day. In other words, they didn't answer any questions to get on that scoring. But the PHQ-2/PHQ-9 was scored at 20 at the top of page 11.
Q What does that score tell us?
DR. CATHERINE BAST: That score tells us that there is major depressive disorder. It confirms the diagnosis.
Q And then it looks like the Vanderbilt screenings were not scored either?
DR. CATHERINE BAST: That is correct. Those screenings are available, but they require -- they require time outside of the office from a parent and for a teacher. So they're only scored once we

Page 121

have gotten that data back from the parent and the teacher -- and a teacher.

Q But in any event, there had already been a diagnosis of ADHD?

DR. CATHERINE BAST: That was a core diagnosis, yes.

Q Yeah. Was it important to address the ADHD before moving on to hormones?

DR. CATHERINE BAST: As I understood it, yes. It's important to address any co-morbid conditions in addition to gender dysphoria. And the depression and ADHD had been under treatment at the psychiatric facility too. So we were -- that treatment had been started, and we were going to continue that.

Q Well, any record of treatment before that, before the hospital?

DR. CATHERINE BAST: I don't have that available, no.

Q So what -- and the treatment for the depression was the fluoxetine; right?

DR. CATHERINE BAST: Uh-huh.

MR. FALK: Yes?

DR. CATHERINE BAST: Yes, yes.

Q Thank you.

Page 122

DR. CATHERINE BAST: My lawyer is telling me that I have to say yes or no, not uh-huh.

Q Excuse me just one second.

Did you think it important to see if the depression would resolve using the fluoxetine or other cognitive behavioral therapy or psychiatric treatment before starting on hormones?

DR. CATHERINE BAST: Given the story, given the history of M.R., and their report that the vast majority of the stressors in their life were related to gender dysphoria, I felt that it was important to treat both in order to help -- to best take care of M.R. In my experience, treating gender dysphoria has resulted in many -- much improvement in depression symptoms.

Q Have you ever been presented with a child that's similar to M.R. that had depression and gender dysphoria, and you've said, no, let's focus on the depression now, worry about hormones later, we want to give alternative treatments for depression a chance first?

DR. CATHERINE BAST: I have not had that experience, no.

Q What do the WPATH guidelines tell you with respect to depression, the co-morbidity of depression?

Page 123

DR. CATHERINE BAST: That any co-morbid conditions be reasonably well controlled.

Q What does that mean to you in your practice?

DR. CATHERINE BAST: It means that to the extent that we can treat -- that the causes of depression have been treated and are being treated, that starting hormones is a part of the care for trans folks. Treating gender dysphoria in addition to treating depression. They are both important. And to the extent that the depression is related specifically to gender dysphoria, treating gender dysphoria is the treatment or part of the treatment for the patient.

Q Is there ever a circumstance where the depression would not, in your paraphrase of WPATH, be reasonably under control so that you shouldn't start with hormone therapy?

DR. CATHERINE BAST: I can tell you that it hasn't happened in my experience, but I can't speculate about hypothetically if that would happen.

Q So you don't have a scenario in your mind of what it would look like if a patient's depression were not reasonably under control?

DR. CATHERINE BAST: Well, in that scenario,

Page 124

they're not in my office. They're still inpatient.

Q Oh, I see. So if a patient with depression is in your office with gender dysphoria, and by definition then, in your view, that depression is reasonably under control?

DR. CATHERINE BAST: Yes.

Q Let's turn over to page 7, please. Just let me know when you're there, Doctor.

DR. CATHERINE BAST: I'm here.

Q On the very top line, it says, "Psychiatric," and then "Insight," and then it says "good judgment." You see that?

DR. CATHERINE BAST: Uh-huh.

Q Can you tell me, first of all, is that an assessment made at Mosaic or was that an assessment made at the hospital?

DR. CATHERINE BAST: That's part of our psychiatric assessment in the office.

Q So that would have -- you made that assessment yourself?

DR. CATHERINE BAST: Yes.

Q And what does that mean when you say -- when you write down "good judgment" by "Insight," what are you basing that on?

DR. CATHERINE BAST: I'm basing that on their

Page 125

responses to my questions. And I'm basing that on their affect and their behavior in the office.

Q What questions do you ask to gauge judgment?

DR. CATHERINE BAST: There aren't specific questions to gauge judgment. This criteria is meant to be a general statement about a person's presence in reality. So if somebody were responding to unseen or unheard others, that would be a reason that they would not have good judgment.

Q I think I got you. Okay. Now, skipping down under "Assessment/Plan."

DR. CATHERINE BAST: Uh-huh.

Q It says, "M.R. is here for an acute to adjust ADHD meds."

Do you see that?

DR. CATHERINE BAST: Uh-huh. Yes.

Q What does this mean?

DR. CATHERINE BAST: What that means is that medication that was started for them previously wasn't working well, and they scheduled an acute appointment in order to discuss changing medicine for ADHD.

Q Okay. Is this -- and at some point have we gone from the first visit to a different visit?

DR. CATHERINE BAST: Yes. Yeah, this is a

Page 126

subsequent visit. Yeah.

Q I'm sorry, what?

DR. CATHERINE BAST: Yeah, this is a subsequent visit.

Q Oh, okay. And then below that under "Transcare: Feels very tired before next shot about day 7. Will divide dose in half and do weekly injections."

Tell us what that's about, please.

DR. CATHERINE BAST: So part of the monitoring of the experience of trans folks on hormones is that different bodies metabolize the medicine different ways, and we have a starting dose and a starting routine or a starting dose and schedule for injections, but that is subject to change based on a patient's metabolism of the medication.

So in this case, M.R. was started on an every other week dose of testosterone. But as happens sometimes with people, their experience was that the testosterone was wearing off, was -- they were feeling fatigue particularly in the day or two -- about day 7 of 14. And so part of the standard practice, then, is to divide the same amount of medicine into more frequent injections, and that's what we switched here to.

Q Any concerns about the impact of the ADHD

Page 127

medication on that metabolism?

DR. CATHERINE BAST: No.

Q What about the fluoxetine?

DR. CATHERINE BAST: The fluoxetine and the guanfacine, in my experience, are not -- do not interfere with the metabolism of testosterone.

Q Was the guanfacine, was that what you switched M.R. to or -- because there's a note about Ritalin just above that, and I'm wondering what the relationship there was.

DR. CATHERINE BAST: So the original medicine that was tried, that was started for M.R., was Ritalin. And that was not being effective for them. And so we switched to guanfacine.

Q Any concern about whether Ritalin might have been interfering with metabolism of the hormones?

DR. CATHERINE BAST: In my experience, that hasn't been an issue, no.

Q All right. Now, dropping down just below the "Transcare," it looks like it says, "follow up 1 month for ADHD," but then it has three numbered paragraphs, and I'm wondering what those are telling us.

DR. CATHERINE BAST: Those are telling us the diagnoses that M.R. carries. Diagnoses codes, yes.

Page 128

Q Sorry. Under "Depressive disorder," it says, "Major depressive disorder, single episode, unspecified," which is -- what is that telling us?

DR. CATHERINE BAST: That is the particular diagnosis code that was given M.R. in the psychiatric hospital, which I then confirmed. If -- it's subject to revision. As I see M.R. more, it may become major depressive disorder unspecified. It could become major depressive disorder. There are a number of different specificities that can be used to describe depressive disorder, and that could change over time. But right now that's the one that was started at the hospital and I carried on.

Q And I see that term "unspecified" under "depressive disorder" and under "gender dysphoria." And I'm wondering what the alternative is. Like, what would be specified? What is something that would be specified?

DR. CATHERINE BAST: Well, major depressive disorder could be more specific, depending on the patient, of multiple episodes, for example. Or it could be related to seasons. So it could be major depressive disorder related to seasonal affective disorder. These are diagnoses codes that are used

Page 129

by insurance companies.
Q Is it relevant for your treatment or is it just relevant for the billing?
DR. CATHERINE BAST: It's more relevant for the billing.
Q Is that true under the -- for the "unspecified" under gender dysphoria as well?
DR. CATHERINE BAST: Yes. The only specification that could be there is a specification of age. And in this case, I didn't specify in the diagnosis M.R.'s age.
Q And by age, you mean specific age as opposed to adult or minor or something?
DR. CATHERINE BAST: Right, specific age.
Q I notice down below there's -- "chief complaint" is depressive disorder and ADHD.
You see that?
DR. CATHERINE BAST: Uh-huh. Yes, I do. Sorry. Stop the uh-huh. Yes.
Q And I guess I'm trying to figure out the relationship between the depressive disorder and this visit, because I thought from earlier, you know, higher up on this page, it was only -- this visit was only about the ADHD, but here it seems to suggest depression was an issue as well. Can

Page 130

you --
DR. CATHERINE BAST: You're seeing multiple visits here.
Q Oh, on this same page there's more than one?
DR. CATHERINE BAST: Yes.
Q Oh, okay.
DR. CATHERINE BAST: So if you see below, you see where we were looking at with the codes and then you see "Encounter Sign-Off," that means that's the end of that visit.
Q Okay. And just before you move on, do you know what date that visit was? Was that on the prior page?
DR. CATHERINE BAST: It looks like -- so we have a run-on of the face sheet into an encounter which I think -- so I think starting on page 5, the appointment date and time is 3-29-2023. And then middle, toward the bottom of page 7, is "Encounter Date: 3-17-2023."
Q Okay. I'm with you now. So 3-29, is that -- is that the most recent encounter date in this set of records?
DR. CATHERINE BAST: It looks like that way, correct. It looks like they're scheduled to see me this week, but I haven't seen them, at least if you

Page 131

look at the last -- page 12, it says, "Return to the office." And it says, "to see Catherine Bast for telemed on 3-14." And then the 3-17 was scheduled for that. And then they're also scheduled around 5-14.
Q Oh, okay. So then we see -- and this is on page 7, you've got this encounter date of 3-17.
DR. CATHERINE BAST: Uh-huh.
Q And follow-up depressive disorder, follow-up ADHD. So this is M.R. asking for, I guess, some way to address both of those symptoms or both of those maladies?
DR. CATHERINE BAST: That was their stated reason for visit, yes.
Q Then a couple lines down under vitals, it says, "None recorded."
Is that typical?
DR. CATHERINE BAST: It is typical if this was a telemedicine visit.
Q Oh, oh, oh. Okay. Is that -- can you tell, is that what this is?
DR. CATHERINE BAST: Yes, this was a telemed visit. If you look under the "HPI," it says, "The technology wasn't working so I saw his face" on telemed "and then called him on the phone."

Page 132

Q Where is that HPI?
DR. CATHERINE BAST: I'm sorry, at the bottom of page 8. It starts there and then moves up to --
Q Oh, oh, moves over. Okay. Got you. All right.
So what, if anything, in this visit did you do for ADHD or depression that you weren't already doing?
DR. CATHERINE BAST: This looks like this was the visit for ADHD where we switched from Ritalin to guanfacine.
Q Okay.
DR. CATHERINE BAST: And in this visit, M.R. reported that their depression felt much better since starting the T. Starting testosterone.
Q Where do you see that?
DR. CATHERINE BAST: Middle of page 9, under the "Assessment and Plan" section. It's the first bullet point under there, or the first entry.
Q So did you -- I mean, but M.R. presented in part to address depressive disorder from the earlier note?
DR. CATHERINE BAST: It was a follow-up. And sometimes a follow-up means it's getting better, right.
Q It wasn't necessarily --
DR. CATHERINE BAST: It was scheduled to

Page 133

address those two concerns.
Q I got it. Okay. It wasn't, Doctor, I'm still feeling bad, come see me; it's, no, here's followup.
DR. CATHERINE BAST: Yes.
Q And then Lexapro, it says, "Stopped taking Lexapro." What is Lexapro?
DR. CATHERINE BAST: Lexapro is another medicine that's used for antidepression. As I recall, this was the one that was started in the hospital and then M.R. stopped taking it.
Q Did you switch M.R. from Lexapro to fluoxetine or was that just on M.R.'s own?
DR. CATHERINE BAST: It's not -- I don't know. Sometimes in our electronic medical record, a new medicine will populate in somebody's med list if they were prescribed it by somebody else. I would have to dig back through to find out where the -- just exactly the dates of the fluoxetine.
Q But your understanding is that M.R. is currently on fluoxetine?
DR. CATHERINE BAST: Based on -- yeah, based on the most recent visit note, which is 3-17. Yeah.
Q And was previously on Lexapro but is no longer?

Page 134

DR. CATHERINE BAST: Correct.
Q Would those have been going -- prescribed at the same time or would you have had to stop one and start the other?
DR. CATHERINE BAST: Typically you stop one and start the other. They're in the same class.
Q Both in the same class in the sense that they're both SSRIs or something else?
DR. CATHERINE BAST: Yes.
Q And, I mean, do you -- does it just -- do different people just react differently to them or is one stronger than the other or anything that's materially different?
DR. CATHERINE BAST: Different people respond differently to different medicines in the same class. Or sometimes it needs to be changed too for insurance reasons, and I don't know in this case what it was. Sometimes an insurance company will cover one and not the other.
Q Yeah. Well, we do have a statement at the top of page 9 that says, "Stopped taking Lexapro, didn't like how he felt on it."
Does that prompt any memories of any discussions with M.R. about how he felt on this, on Lexapro?

Page 135

DR. CATHERINE BAST: What I remember M.R. telling me is that they forgot to take it and then also didn't like how they felt when they were on it in the hospital.
Q Any more specificity than that, other than not liking how they felt?
DR. CATHERINE BAST: No. Other than he reported that his mood had improved significantly since taking the testosterone.
Q Right. Okay. So over on 11, I guess I'm not even sure which encounter this is, it probably is -- I don't know. Can you tell me what -- on page 11 which encounter this is?
DR. CATHERINE BAST: It looks like 2-15-2023.
Q Okay. Under "Assessment and Plan. Patient meets the WPATH criteria for initiation of hormone therapy," et cetera. And then under No. 1, it says, "Persistent, well-documented gender dysphoria."
What documentation of gender dysphoria for M.R. did you have at this point?
DR. CATHERINE BAST: I had the report of the parents, and I also had the discharge summary and the papers from the Michiana Behavioral Health.
Q Michiana Behavioral Health documents were, what,

Page 136

two weeks old at this point?
DR. CATHERINE BAST: That's correct.
Q And what documentation from the parents did you get?
DR. CATHERINE BAST: I got their report on his experience.
Q Their just oral report; right?
DR. CATHERINE BAST: Correct.
Q No documents?
DR. CATHERINE BAST: I do not have physical documents from previous physicians, no.
Q I guess then, I mean, it says documented -- "well documented." Is an oral report documentation?
DR. CATHERINE BAST: In the sense that it is a history provided by the patient and the patient's parents over time, I took that as documentation, yes.
Q It's a totally -- I mean, it's totally retrospective, though. It's not a report as time goes on. It's looking back, here's what we are reporting?
DR. CATHERINE BAST: Correct.
Q And that's what you think documented or well documented means under the WPATH standards?
DR. CATHERINE BAST: As I understand the WPATH

Page 137

standards, they want a person to have had gender dysphoria over time. Often the only way that is documented in any capacity is in the family.

Q Well, and it says "well documented." And I'm just trying to figure out, you know, an oral history isn't -- I mean, somebody telling you something isn't documentation.

MR. FALK: I'm going to object. You're arguing with the witness.

MR. FISHER: You're right, and I'm sorry.

MR. FALK: You asked if it was documented. She's explained to you that hearing from the patient and the parents is documentation, and you're saying it's not. And that's your opinion, but she's answered the question.

MR. FISHER: Fair enough. Fair enough. Fair enough. Fair enough.

Q So below all of that, on page 11, under "gender dysphoria," it says, No. "1, Gender dysphoria." Are you with me?

DR. CATHERINE BAST: Yes.

Q And then a couple bullet points down it has testosterone, but it also has estradiol. And I'm wondering, what is this telling us?

DR. CATHERINE BAST: That is a list of the

Page 138

labs that were created in relationship to this visit. So I ordered a complete blood count. I ordered a comprehensive medical panel. I ordered a testosterone level and an estradiol level.

Q Estradiol. Pardon my pronunciation. Great. And the then No. 2, what is that telling us?

DR. CATHERINE BAST: So again, so this is the list of the diagnoses that are associated with this encounter.

Q Okay. So over on page 13, this may be our missing informed consent form for -- not missing, my fault on that -- on the hormones. So this is the form you use when people are going on hormones?

DR. CATHERINE BAST: This is one page of a packet. And this is the page with the signatures on it that we scan into the chart.

Q All right. Then the next page, what is this telling us?

DR. CATHERINE BAST: So the next pages are the -- what's available to patients in their patient portal to answer questions related to their conditions. So every patient has the opportunity to go in and do -- indicate yes or no on the first section and then put in any surgical history, any

Page 139

gyn history, any family history that they choose.

Q Oh, I see. Okay. So this is all patient entered information?

DR. CATHERINE BAST: It's all patient entered, yes. And then it looks like there's another copy of the informed consent document.

Q But the patient entered information continues over to 15?

DR. CATHERINE BAST: Correct. So --

Q Yeah.

DR. CATHERINE BAST: Yeah, so you can see at the bottom of 15, that's -- the patient entered the answer to the question of, what is your stress? "Do you feel stressed?"

Q Right. And that same -- and so when the patient entered this, then that just -- did that populate the other pages?

DR. CATHERINE BAST: Yes, it did. It did.

Q So then we've got -- oh, on page 17, is that -- are those the lab reports?

DR. CATHERINE BAST: Yes.

Q Same thing with 18?

DR. CATHERINE BAST: Yes.

Q 19 is the Michiana discharge cover letter?

DR. CATHERINE BAST: Yeah. Yes.

Page 140

Q I'm just flipping through to see if there's anything worth asking you about.

MR. FISHER: I think I'm done with that record, but everybody want to take five?

MR. FALK: Sure. Thank you.

(Recess taken.)

(Deposition Exhibit 16 marked.)

BY MR. FISHER:

Q Dr. Bast, we're going to authenticate some documents. Do you see two additional exhibits, Exhibit 16, which says "Informed Consent for balancing hormones in Gender Diverse people" and then "Increasing testosterone"; do you see that one?

DR. CATHERINE BAST: Yes.

Q Okay. Is this the informed consent form you used when prescribing testosterone to a natal female who is undergoing gender -- or has gender dysphoria and is seeking hormone treatment?

DR. CATHERINE BAST: Yes.

Q Okay. And is there any other form that you use for such patients?

DR. CATHERINE BAST: I think we submitted a couple of general -- well, there was one for parents and -- but there is a general information

Page 141

about masculinization social transitions, and then also a general document about feminization social transitions.

Q You're holding them up. I appreciate that. I'm not sure I can see them.

MR. FALK: You should have those as well, Tom. They're one-page forms.

MR. FISHER: Yeah, yeah.

MR. FALK: They say REV02072022 at the top left-hand corner.

MR. FISHER: Sorry, what was that, Ken?

MR. FALK: They have in the top left-hand corner something that I think says REV02072022; Revised February 7, 2022.

MR. FISHER: All right. Okay, so we're going to look for those.

(Deposition Exhibit 17 marked.)

BY MR. FISHER:

Q Okay, so that was Exhibit 16. Exhibit 17, then, is -- it says, "Informed Consent for balancing hormones in Gender Diverse people." And then below it says "Increasing estrogen."

DR. CATHERINE BAST: Correct.

Q Is that the same form, informed --

DR. CATHERINE BAST: This is a packet. Yes.

Page 142

Q Yeah. Well, I've got -- right, I've got several pages for each.

DR. CATHERINE BAST: Correct. There's going to be -- there should be three pages double-sided each. Or at least one of them is -- had only five sides.

MIXHI MARQUIS: 16 is five pages.

Q Right, right.

DR. CATHERINE BAST: Yes.

Q And then 17 is six pages?

DR. CATHERINE BAST: Correct, uh-huh.

Q But as described as in front of you, those are complete and accurate copies of your informed consent for the hormone treatment?

DR. CATHERINE BAST: Yes.

Q Okay. And then we'll see if we get the others that you were talking about here in a minute, but for now I just -- I just wanted to get those in. And we'll get those to the court reporter for inclusion in the record.

Okay, I had a follow-up question about M.R. and the ADHD diagnosis. Did you take any particular steps to accommodate M.R.'s ADHD when explaining the risks, benefits, potential side effects, other relevant facts about hormone

Page 143

treatment?

DR. CATHERINE BAST: When I am communicating with patients, I am checking in with them to be sure that they're hearing what I'm saying. I ask for them to tell me what they've heard. And yeah, confirming with every patient that they're understanding what I'm saying. So yes, with each patient, I do work to be sure that they're understanding -- we're understanding each other.

Q Have you discussed the potential for surgery with M.R.?

DR. CATHERINE BAST: To the best of my knowledge, no.

Q Mixhi, I think we're going to move over to you for just a few minutes. I hope you haven't felt left out.

MIXHI MARQUIS: Not at all.

Q We talked a little bit earlier about your training -- or the trainings that you perform.

MIXHI MARQUIS: Uh-huh.

Q I just had a couple of follow-ups. The peer consultation, I think it's in paragraph 8 of your declaration.

MIXHI MARQUIS: And which paragraph?

Q Paragraph 8. It says the trainings include

Page 144

"supplying provider training as well as engaging in peer consultation with other providers." And I'm wondering what that means.

MIXHI MARQUIS: That means that those folks who have come through our continuing ed training have had the ability to reach out to Dr. Bast and our mental health provider to -- yeah, to kind of, if they have situations or things that they want to -- aren't sure about or want to learn further or have questions, they can ask them.

And then I -- and then we also have that on the not clinical side. So offices can reach out to me.

Q Oh, okay. So that's both clinical and nonclinical that you have these peer consultations?

MIXHI MARQUIS: Yeah, and the consultations are appropriately clinical or nonclinical depending on where they're coming from.

Q For the nonclinical, what types of topics do you cover in these consultations, typically?

MIXHI MARQUIS: We cover -- we often present statistics on kind of the disparities in mental health and outcomes for LGBTQ folks. We do a little bit of foundation building on kind of our understanding of gender identity and sexuality. We

Page 145

recommend or kind of present some ways to say things that are not so gendered.

We often invite questions from the folks that are there to -- if they've had situations that they're not sure if they could have handled differently, we might talk about those. We talk about using correct pronouns and name and how to interact, how to ask that of folks, how to do intake paperwork that is welcoming to the folks in the LGBTQ community. That's about it.

Q Okay. What about on the clinical side, and whether it's Dr. Bast or you, Mixhi, either one, wondering what those consultations are like.

DR. CATHERINE BAST: Are you referring to the provider training or are you referring to the consultations post provider training?

Q I think -- well, let's just start with the training. We talked about it a little bit earlier, but it doesn't hurt to just touch on that again. What's in the provider training?

MIXHI MARQUIS: So the provider training includes suggestions and recommendations for how to create a welcoming space so that LGBTQ people feel welcome and safe for accessing care. And then with the medical providers, I also go into specific

Page 146

situations. I teach about HIV care, how to take care of HIV, how to do STI testing and training, how to do prep and also how to do hormones for gender-affirming hormones.

Q I mean, I guess on the latter point there, are you effectively trying to teach the WPATH guidelines or what are you teaching in that regard?

DR. CATHERINE BAST: Yes, yes.

Q And then on the follow-up, once you've had the trainings, then I guess that's when the consultation comes in; is that right?

DR. CATHERINE BAST: That's correct.

Q And then what does that consist of, usually?

DR. CATHERINE BAST: It's completely dependent upon the provider. The provider sometimes will reach out and say, I have a question about this or this was a lab result that I got, help me understand this. Yeah, typically those are the kinds of questions I get.

Q I mean, is it any different in the gender dysphoria context than in any other practice, medical practice context?

DR. CATHERINE BAST: No.

Q I mean, I guess I would have expected doctors are always talking to each other about that sort of

Page 147

thing?

DR. CATHERINE BAST: (Affirmative nod.)

Q Yeah. Can you give me just a verbal there? You were nodding.

DR. CATHERINE BAST: Oh, sorry. Yes, that is exactly what's happening. Doctors are talking to each other about care.

Q Okay. So I think probably back to Mixhi with the next one.

What is the amount of Mosaic's Medicaid billings for treating gender dysphoria in minors?

MIXHI MARQUIS: We do not have that information. Yeah. That would require us going into absolutely every chart. And because we also do primary care, determining what was care for primary care, what was care for gender dysphoria.

Q Has Medicaid ever, to your knowledge, ever refused to pay for a service offered by Mosaic on the grounds that it was not medically necessary?

MIXHI MARQUIS: Not to the best of my knowledge.

MR. FALK: Tom, just -- I know the question has been asked, but are you referring to any medical service at Mosaic?

MR. FISHER: Yes, yes.

Page 148

Q Same answer?

MIXHI MARQUIS: Yeah, to the best of my knowledge, no.

Q Does Mosaic believe that Medicaid would stop paying for gender-affirming medical services after SEA 480 goes into effect?

MIXHI MARQUIS: I guess that was my understanding.

Q And what's the basis for that understanding?

MIXHI MARQUIS: That those -- the services defined in -- under the law, under SEA 480, would no longer be legal to do in Indiana.

Q Is that -- that's it, nothing else?

MIXHI MARQUIS: That's correct.

Q So paragraph 16, it says you have three appointments scheduled this week, and this is dated 4-21-23. Three appointments scheduled this week for persons under the age of 18 that are Medicaid recipients. These are new patients not included within the total number of patients that you previously had mentioned?

MIXHI MARQUIS: Uh-huh.

Q And so I wondered, with the time you submitted this declaration, had those patients been evaluated for gender dysphoria? Had there been any diagnosis at

Page 149

all?
MIXHI MARQUIS: I do not know the answer to that. They are people who reached out and requested new patient appointments for us regarding interest and experience in gender dysphoria.
Q And I'm taking it also that they were on Medicaid; right?
MIXHI MARQUIS: Uh-huh.
Q Yes?
MIXHI MARQUIS: Yes. Sorry.
Q So in paragraph 17, you say that the frequency with which you're accepting new minor transgender patients will ultimately receive puberty blockers and/or gender-affirming hormones is increasing.
You see that statement?
MIXHI MARQUIS: Yes.
Q Is that still true?
MIXHI MARQUIS: Yes.
Q What is your basis for the statement that it is increasing?
MIXHI MARQUIS: It's the number of appointments that we are seeing on a weekly basis has increased over time.
Q Specifically for blockers or hormones?
MIXHI MARQUIS: No, specifically requests from

Page 150

minors who identify as transgender.
Q Well, it also says that patients who ultimately receive those.
MIXHI MARQUIS: Uh-huh.
Q And so I'm wondering how you --
MIXHI MARQUIS: Yes, that's what it says.
Q Have you gone back to check that or is that just an assumption based on what they told you on the phone?
MIXHI MARQUIS: That is not something they would tell us on the phone. They would tell us if they were -- they might or might not tell us if they're coming specifically for puberty blockers or gender-affirming hormones. They would tell us that they were coming for gender-affirming care, and that may or may not include puberty blockers or gender-affirming hormones.
Q So does that -- did you go back and look at the -- what happened with those patients to confirm that they were prescribed blockers and/or hormones?
MIXHI MARQUIS: I have not.
Q In the context of that dynamic that you're observing here, how are they split between natal males and natal females, roughly?
MIXHI MARQUIS: I don't have that information.

Page 151

Q In paragraph 20, you say that if SEA 480 takes effect Mosaic will want to cooperate when out-of-state practitioners contact Mosaic staff to discuss former minor patients and to provide medical records as authorized by the patient so the patient can receive continuity of care.
MIXHI MARQUIS: Uh-huh.
Q Now, your understanding, which I think you then convey in paragraph 21, is that if SEA 480 goes into effect, you will not be permitted to do that by virtue of the aiding or abetting language?
MIXHI MARQUIS: Correct.
Q Do you -- would you be able to provide the medical records to the patients themselves?
MIXHI MARQUIS: If they asked for their medical records, yes, we could provide them to them. If the patient themselves does, or parents.
Q When you are talking about providing referrals to other providers, whether it's in-state or out-of-state, and I'm just talking right now, what does that mean, providing a referral? What specifically is Mosaic doing when that happens?
MIXHI MARQUIS: Providing a referral would be specifically a document, or we would literally send a referral through our electronic medical records

Page 152

system, referring someone officially to another space or to another provider.
Q Anything else?
MIXHI MARQUIS: No.
Q Do you know how many referrals Mosaic has received from other providers in 2023?
MIXHI MARQUIS: From other providers specifically for trans youth --
Q Sure, yeah.
MIXHI MARQUIS: -- or for everyone?
Yes, we have received approximately -- well, actually, I don't know how many in the last year. But of our current trans youth patients, approximately 13 of them were referrals from other places.
Q That's just among your current patient population, regardless of when that happened, that's the number?
MIXHI MARQUIS: Correct, correct.
Q Do you have that broken down over time at all?
MIXHI MARQUIS: No.
Q In paragraph 21, again, back on this aiding and abetting issue, you talk about not being able to respond to, quote/unquote, inquiries from other practitioners. And I'm wondering what you mean by

Page 153

inquiries.

MIXHI MARQUIS: It's our understanding that if we have any communication about the services that will be banned under 480, if we have any communication with another provider who may provide gender-affirming care in those banned services, that it is possible that we could -- that Dr. Bast or other providers could lose their licensure in Indiana or have discipline against their licensure.

Q Yeah. Fair enough. I just wonder, the word "inquiries" is pretty broad, and I'm just wondering specifically, are there inquiries that frequently come up currently that you're concerned about, or what are inquiries?

MIXHI MARQUIS: It would be the folks that we already are in touch with that we've trained that reach out for consultation from our -- the normal doctor discussions that you talked about earlier.

(Deposition Exhibit 15 marked.)

Q All right. Let's look at Exhibit 15.

Mixhi, can you tell me what this document is?

MIXHI MARQUIS: This is a list that we have -- it's kind of an evolving list of mental health providers. We do have a mental health provider at Mosaic. However, we do not accept insurance for

Page 154

our mental health provider, so often, whether it's because of where someone lives that there might be somebody closer to a person, or that they need someone who will take insurance, we provide this list of counselors as a list of folks who we've had feedback from other patients or that we've talked to personally to know that they're doing -- that they're serving LGBTQ folks.

Q So this is just mental health?

MIXHI MARQUIS: This is just mental health.

Q Do you have a similar list of medical providers?

MIXHI MARQUIS: No.

Q In paragraph 22 of your declaration, you talk about awareness of physicians and clinics providing gender-affirming care to minors?

MIXHI MARQUIS: Uh-huh.

Q And it says that you'll make referrals to these providers, and I'm wondering who they are, which providers you're talking about.

MIXHI MARQUIS: Yeah, so Eskenazi in Indianapolis, Riley. We have in the past Lurie in Chicago. Again, most of those are because of proximity that those might be easier to access for folks.

Q Anybody else?

Page 155

MIXHI MARQUIS: No. I don't believe so. And I do want to say, in the definition of referral that I gave you earlier, to the best my knowledge, we haven't made a formal referral to any of those places. Generally, it's something that will come up in a patient appointment. And if a provider understands that the person lives somewhere closer to one of those places, they will offer the information of Riley or Eskenazi or Lurie existing, and then the patient may choose to go there instead. But we have not -- we have actually not made any formal referrals.

Q So paragraph 20 of your declaration -- here we go. This might be in the other declaration.

So Dr. Bast, I finally found what I was looking for. It's back in your declaration, Exhibit 7, paragraph 24. Just let me know when you're there.

DR. CATHERINE BAST: I have it in front of me.

Q Okay. So paragraph 24, and it speaks in terms of an ethical obligation. Ethically obligated to cooperate when out-of-state practitioners contact me to talk about my former minor patients at their request and provide patient's -- my patient's medical records to out-of-state practitioners, as

Page 156

authorized by patients, so that the patient can receive continuity of care.

What is the source of that ethical obligation?

DR. CATHERINE BAST: I am ethically obligated to continue to care for a patient with whom I have already started care. I am ethically obligated to communicate with other physicians about their care if asked.

Q Have you taken any steps to connect any of your patients with out-of-state providers in advance of the effective date of SEA 480?

DR. CATHERINE BAST: We've been in the data collection phase, trying to find out what's available for patients, yes.

Q Do you have a plan in place to provide out-of-state referrals in advance of the effective date of SEA 480?

DR. CATHERINE BAST: Yes, we have a number of different plans in place.

Q What are those plans?

DR. CATHERINE BAST: We want to provide patients with the optimum in coordination of care. So ideally I would have -- we have planned for a referral and a handoff directly to an out-of-state provider. I know that many of my patients will

Page 157

not -- that will not be financially feasible for them, either for transportation reasons or because they have Medicaid and that won't be covered in another state. I have many patients for whom out-of-state referrals are not possible or practical.

Q But for those whom it is practical, you have a plan in place to hand off?

DR. CATHERINE BAST: We're dealing with each individual patient, yes, about what their needs and desires are moving forward.

Q Well, I'm just curious, when you say you have a number of plans in place. I'm just wondering what --

DR. CATHERINE BAST: Each plan --

MR. FALK: Let him finish.

DR. CATHERINE BAST: I'm sorry. Go ahead.

Q Are you just telling me that for each patient, you have to sort of address that individually and that's why you have a number of plans in place?

DR. CATHERINE BAST: Yes.

Q All right. But this is something that's on your mind, I guess, and something that you are addressing in anticipation that this law is going to go into effect?

Page 158

DR. CATHERINE BAST: Absolutely.

Q So paragraph 20 --

MR. FALK: You're talking to Dr. Bast, Tom?

MR. FISHER: Yes, Dr. Bast.

Q It says, "Moreover, I'm obligated under the Affordable Care Act to provide this medically necessary care to my patients."

And I'm wondering what you understand the Affordable Care Act to require of you in this paragraph that you're stating in this paragraph.

DR. CATHERINE BAST: As I understand it, the Affordable Care Act prohibits me from discriminating against anybody in giving care, and that if I cannot give medically necessary care to a patient, then I need to find -- to do my best to find another provider who can. And LGBTQ folks are protected as one of those protected classes. So I cannot discriminate by saying that I will not give care to an LGBTQ person. And if I feel like -- if there are specific care needs of these people that are not within my scope or within my training, then I am obligated to refer them to somebody who is.

Q Is it your understanding that that obligation, that Affordable Care Act obligation, applies regardless whether the patient is enrolled in Medicaid or some other federally funded medical program?

Page 159

DR. CATHERINE BAST: My understanding is that the Affordable Care Act applies to federally funded programs.

Q Would -- and obviously Medicaid would fit within that. Any other federally funded programs that cover your patients besides Medicaid, for your gender dysphoria patients?

DR. CATHERINE BAST: Do you mean just minors or --

Q Yeah, just minors, yes.

DR. CATHERINE BAST: I think Medicaid is the only one.

Q What do you tell your patients, Doctor, about SEA 480?

DR. CATHERINE BAST: Well, we've been talking about it with patients at every stage, from when it was proposed to when it was being heard to finally its passing. And what we say is that under SEA 480, we are no longer going to be able to provide any gender transition procedures and that we are going to need to discuss with them what that means, what the consequences to them will be, and how we move forward with their care.

Q When did you first start having those conversations?

Page 160

DR. CATHERINE BAST: As soon as the bill was introduced.

Q So sometime in 2023 or as far back as November of '22?

DR. CATHERINE BAST: My patients have been asking about this possibility since November of 2022. I did not have much information until January of '23 when the bill was introduced. My patients are very worried about this, and I am -- I am regularly having patients in tears in my office. I have patients asking me, why are they doing this to me? What is wrong with me that they don't like me so much? I had a patient ask me if they needed to be worried about people coming with guns and rounding them up and taking them away.

Q And what did you tell them?

DR. CATHERINE BAST: I said that I didn't think that it was going to be this law that would do that, but that I was worried about the pattern of discrimination that I was seeing in the U.S., especially of transgender people. I've done a lot more crying with my patients than I have ever done before. I have patients telling me they're going to kill themselves.

Page 161

Q Anything else?
DR. CATHERINE BAST: That's all.
MR. FISHER: Ken, we may be about done. Let's take five and come back. We'll see where we are.
(Recess taken.)
(Deposition Exhibit
(Deposition Exhibit 18 and Exhibit 19 marked.)
BY MR. FISHER:
Q So earlier we talked about a couple of documents that you've sent along that I didn't have in my exhibit -- my set of exhibits that I sent. I'd like to just get those identified and entered in. And we've e-mailed them to the court reporter as well, so hopefully, those show up.
Exhibit 18 will be the document that says "Feminizing Social Transitions: What to know." And Exhibit 19 will be "Masculinizing Social Transitions: What to know."
MR. FISHER: Ken, do you have those documents?
MR. FALK: Thank you. They're in front of her. Thank you.
Q So Doctor, looking at Exhibit 18, can you tell me what this document is?
DR. CATHERINE BAST: Yes, this is an informational document that we provide to folks who

Page 162

are interested in feminization, just for their knowledge and for -- to share with whoever they choose.
Q Do you consider it part of your informed consent process?
DR. CATHERINE BAST: I don't necessarily refer back to these documents the way I would refer back to other documents in the informed consent process. But yes, it's a part of information sharing.
Q And then let's go ahead and look at Exhibit 19, please, and just tell me what that document is.
DR. CATHERINE BAST: This also is an information sharing document about masculinization and information about what's available in terms of -- about ways to engage in a social capacity as a different gender and things that might be available to assist in gender congruence.
MR. FISHER: Okay. I think that's all the questions I have, Ken. I'll turn it over to you.
MR. FALK: Thank you.
EXAMINATION
BY MR. FALK:
Q Doctor, at the very beginning of this deposition, I think both you and Mixhi were asked about the declarations that you had submitted that are

Page 163

exhibits, I believe, 6 and 7. And you were asked if everything was still the same. Have the raw numbers of patients that are noted in those declarations changed?
DR. CATHERINE BAST: Yes. Those may have changed.
Q And you were asked some general questions about the gender-affirming care that you provide. Is that care deemed to be clinically safe?
DR. CATHERINE BAST: Yes, it is.
Q And on what do you base that answer?
DR. CATHERINE BAST: Based both on the best of clinical research but also my experience.
Q And you were asked a series of questions about diagnosing gender dysphoria.
DR. CATHERINE BAST: Yes.
Q And I think questions were asked about what do you listen for or what is told to you. What do you listen for?
DR. CATHERINE BAST: So there isn't a test. There isn't a blood test to diagnose gender dysphoria. There isn't a form that needs to be filled out or anything like that. But I am listening for examples of behavior that indicates gender incongruity.

Page 164

So, for example, a child identified male at birth who wants to dress in traditionally female ways and doesn't want to be referred to as a boy and engages in all kinds of activities as a girl and expresses distress. Some trans children express distress at their body parts.
I'm listening, some trans children who are -- have a penis express distaste for their penis, sometimes even going so far as to saying they want to cut it off. Sometimes they draw pictures of themselves. As they draw pictures and label them things like the freak and it's a picture of themselves as a girl with a beard or ...
Q Do you frequently hear reports from the youth or parent about self-harm being --
DR. CATHERINE BAST: I do. I hear a lot of self-harming behavior. I hear not only the desire to harm the body part that doesn't feel like it exists, whether it's in adolescent breasts that have already developed or a penis that is already there, but I also have reports of self-harm, cutting, tattooing, self-tattooing as a way of dealing with the distress.
I have reports of adolescents expressing so much dismay with their body parts, their breasts,

Page 165

for example, that they wrap them in duct tape because they don't want to look at them and they don't like them.

Q You were asked questions particularly about M.R. about depression. Setting aside major depressive disorder, the actual diagnosis, is it common that the youth that you -- come to you for gender-affirming care are unhappy and depressed in the nondiagnostic sense?

DR. CATHERINE BAST: Yes. I mean, in fact, by definition, there needs to be distress in order for gender dysphoria to be diagnosed, and that distress can be expressed in all kinds of ways. Some of the ways I've talked about, but also emotional, expressions of emotional depression.

Q When are puberty blockers -- when can they first be prescribed to a transgender youth?

DR. CATHERINE BAST: Yeah, they're indicated once a person has entered puberty, so -- and that's documented by Tanner stages. And the Tanner stage 2 is the place at which puberty blockers are indicated.

Q So before Tanner 2, there is no medication response to gender dysphoria?

DR. CATHERINE BAST: Correct, correct.

Page 166

Q You were asked some questions about the side effects of testosterone and estrogen.

DR. CATHERINE BAST: Yes.

Q And you were asked for some specific side effects by Mr. Fisher.

DR. CATHERINE BAST: Yes.

Q Are those side effects of the drug regardless of whether it's being given to someone for gender dysphoria or to assist gender persons for other reasons?

DR. CATHERINE BAST: Yes. They are the same side of estradiol given to a person with gender dysphoria has the same potential side effects as given to somebody who does not have gender dysphoria, with the exception of how the estradiol impacts the gonads or then the testosterone is the same way. The side effects given -- no matter to whom they are given, the potential side effects are the same except as they impact the gonads that are present.

Q And are there situations where cisgender persons may for whatever reason be -- a cisgender male may be prescribed testosterone or cisgender female may be prescribed estrogen?

DR. CATHERINE BAST: Yes.

Page 167

Q And at the end of the deposition, both you and Mixhi were asked questions about referrals.

Do you remember that?

DR. CATHERINE BAST: I do.

Q Are there times when you make a referral by just telling a patient that there may be someplace else that that patient can go?

DR. CATHERINE BAST: Absolutely. In the context of conversation about their care, I might, yeah, give them information about where care is available and where they could get it.

Q And do you think that that will be prohibited if this law goes into effect?

DR. CATHERINE BAST: It's my understanding that that also will be prohibited under SEA 480.

MR. FALK: I don't think I have anything further unless Mixhi feels bad that I didn't ask her any questions.

MIXHI MARQUIS: No.

MR. FALK: Just one moment, if we could go off the record for one second. We can stay on screen.

(Discussion held off the record.)

MR. FALK: I have no further questions. Thank you.

MR. FISHER: I do have a few follow-ups.

Page 168

EXAMINATION

BY MR. FISHER:

Q So back to when Mr. Falk was asking you what you listened for and you're listening for statements about how the person likes to dress that maybe is more typical of the opposite sex, activities that may be more typical of the opposite sex, distress about body parts, I guess I'm wondering, in your understanding of gender dysphoria, does the person desire only those outward manifestations of gender?

DR. CATHERINE BAST: I'm not sure I understand the question.

Q Is it sufficient for somebody with gender dysphoria to dress like, for example, a natal male who has gender dysphoria, to dress as a girl, to play with girls, to do activities, whatever those might be, more typical for girls, is that -- does that address their gender dysphoria?

DR. CATHERINE BAST: In my experience, it helps. The make or break point in my experience is puberty. The point at which the body starts to change and somebody who was assigned female at birth but who is -- identifies as male, then all of a sudden starts to develop more feminine characteristics, and the distress increases as

Page 169

it -- they describe to me that their bodies betray them.

Q And is it related only to these observable secondary sex characteristics?

DR. CATHERINE BAST: I certainly hear about the observable secondary sex characteristics in my office frequently. They don't -- they don't need me -- there's lots of distress with gender dysphoria. And some of it is psychological. Some of it is medical, yeah.

Q Do people with gender dysphoria want to be the opposite sex?

DR. CATHERINE BAST: In my experience, people with gender dysphoria are the opposite sex. Their bodies just don't reflect that.

Q Interesting. When you were commenting on what some natal girls do when they grow breasts with the duct tape, are there accepted alternative and appropriate ways for natal girls to deal with that?

DR. CATHERINE BAST: I think there are safer ways than duct tape. Many trans men bind their breasts often with specially designed clothing to attempt to flatten the chest.

Q Is that something you talk about with your patients?

Page 170

DR. CATHERINE BAST: If they ask me, yes, I do.

Q What do you tell them about that?

DR. CATHERINE BAST: We talk about binders that are available, recommendations for taking a binder off certain hours of the day, how to take care of a binder, how to size a binder.

Q Is it your understanding that under SEA 480, binders will be against the law?

DR. CATHERINE BAST: Yes. That's my understanding.

Q You were asked about the side effects of estradiol and testosterone, the idea being that the side effects will exist regardless of whether it's for gender dysphoria or something else.

Do you remember that discussion?

DR. CATHERINE BAST: Yes, I do.

Q And so you said, well, there are times when a cisgender woman might be prescribed estradiol.

DR. CATHERINE BAST: Yes.

Q What indications, what circumstances would that happen?

DR. CATHERINE BAST: In a hypoestrogen state.

Q Any particular, I don't know, syndrome or anything come to mind? I don't know when that would arise.

Page 171

DR. CATHERINE BAST: We often -- there are often conditions in post menopausal women that require or that where the recommended care is estrogen supplementation.

Q Is the estrogen in that circumstance given at the same volume as a transgender woman who's seeking to develop feminine characteristics?

DR. CATHERINE BAST: The dosing is dependent upon each individual. The dosing for estradiol in a trans woman does not exceed that which would have been produced by the gonads of a cis woman.

Q Is the estradiol generated by the gonads of a cis woman apt to cause the same side effects as estradiol given as part of hormone therapy to a trans person?

DR. CATHERINE BAST: To the best of our knowledge, yes. Estradiol is estradiol.

Q Okay. And what about testosterone, what are the circumstances for giving testosterone to a cis man?

DR. CATHERINE BAST: Hypogonadism, for example. So a malfunction of the gonads in their production of testosterone.

Q And is that given in the same volume as given to a trans man?

DR. CATHERINE BAST: It's completely dependent

Page 172

upon the person being treated and what their -- and monitored in the same way to keep the testosterone range in the normal range for a cis man.

Q The testosterone produced naturally by a cis man versus testosterone for an exogenous or -- any difference in whether those are likely to cause side effects?

DR. CATHERINE BAST: I know that the risk profile or the theoretical side effects potentially caused by exogenous hormones are based on observations in cis people.

MR. FISHER: Okay. I think that's it.

MR. FALK: I have nothing further.

And I neglected to say this. You have the opportunity to review the transcript of the deposition. You cannot make substantive changes, but sometimes there are typos or what have you, we can do an errata sheet. You would waive that right. I would suggest that you review, and then you'll have an opportunity to sign it.

DR. CATHERINE BAST: Okay.

MR. FALK: So we'll take signature, and I think Stevie put in that we wanted expedited.

Stevie, is that correct?

Stevie is not on, but she's -- I think we were

in touch with Stewart about that; correct?
THE REPORTER: I had that someone needed it by the 22nd? Is that correct, or do you need it sooner?
MR. FISHER: I think that we may have said that, but I would also like a rough, I've decided.
THE REPORTER: That's fine.
MR. FALK: We do not need a rough, but we would like it expedited.
(The deposition concluded at 3:42 p.m.)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., ET AL.,	)	
	)	
Plaintiffs,	)	
	)	
-v-	)	CASE NO.
	)	1:23-cv-00595-JPH-KMB
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,	)	
	)	
Defendants.	)	

Job No. 181516

We, DR. CATHERINE BAST and MICHELLE (MIXHI) MARQUIS, state that we have read the foregoing transcript of the testimony given by us at our deposition on May 15, 2023, and that said transcript constitutes a true and correct record of the testimony given by us at said deposition except as we have so indicated on the errata sheets provided herein.

_____
DR. CATHERINE BAST

_____
MICHELLE (MIXHI) MARQUIS

STEWART RICHARDSON & ASSOCIATES
Registered Professional Reporters
One Indiana Square, Suite 2425
Indianapolis, IN 46204
(800)869-0873

STATE OF INDIANA
COUNTY OF HENDRICKS

I, Debbi S. Austin, a Notary Public in and for said county and state, do hereby certify that the deponents herein were by me first duly sworn to tell the truth, the whole truth, and nothing but the truth in the aforementioned matter;

That the foregoing deposition was taken on behalf of the Defendants; that said deposition was taken at the time and place heretofore mentioned between 9:37 a.m. and 3:42 p.m.;

That said deposition was taken down in stenograph notes and afterwards reduced to typewriting under my direction; and that the typewritten transcript is a true record of the testimony given by said deponent;

And thereafter presented to said witnesses for signature; that this certificate does not purport to acknowledge or verify the signature hereto of the deponent.

I do further certify that I am a disinterested person in this cause of action; that I am not a relative of the attorneys for any of the parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 22nd day of May, 2023.

My Commission Expires:
July 13, 2023

Job No. 181516

F